

# Overarching Communication Strategy for Programs in Family Planning, Maternal Child Health, Nutrition, HIV/AIDS & Education in Guatemalan Western Highlands



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## 1. Introduction

In June 2010, the USAID mission in Guatemala requested assistance from C-Change to strengthen the capacity for social and behavior change communication (SBCC) among the USAID/Health and Education Office (HEO) staff, partners and counterparts. USAID/HEO manages a wide portfolio of health, education and social sector projects. Currently there is no HEO SBCC strategy document connecting each of these activities and focus areas. This document presents an overarching communication strategy for HEO supported programs and FP, MCH, Nutrition, HIV/AIDS and Education in Guatemala using the C-Change approach to SBCC.

This strategy will ensure that SBCC interventions (i.e. peer education/outreach, supportive communication materials, advocacy, social media etc.) are targeted and tailored to address barriers to social and behavior change, using an approach that combines interventions appropriate to audience life-stages.

**Communication for Change (C-Change)** is a USAID-funded project to improve the effectiveness and sustainability of social and behavior change communication (SBCC) activities and programs as an integral part of development efforts in health, and civil society strengthening. C-Change works with global, regional, and local partners to apply communication approaches to change individual behaviors and social norms, supported by evidence-based strategies, state-of-the-art capacity strengthening (CS), and operations and evaluation research

It was developed through a collaborative process and with the support of the Health & Education Office (HEO) at the USAID Mission in Guatemala and USAID Washington DC. Key steps included:

- Review of findings from a 2010 consultant report of SBCC capacity and challenges within the Guatemala HEO associated with creating a more integrated SBCC program.
- Literature reviews, interviews with USAID staff and partner organizations, and an abbreviated review of existing strategies, programs and communication materials supporting HEO interventions in family planning (FP), maternal & child health (MCH), nutrition, HIV/AIDS, and education.
- Workshops and planning sessions with the HEO officers to identify and capture a situation analysis across sectors including key SBCC challenges, research gaps, and identification of effective tipping points for social and behavioral change; strategy design with audience segmentation, SBCC objectives, key content; and indicators for measuring success for each of the priority interventions.

- Development of health specific communication strategies for (mention the areas here) , developed by C-Change. These 5?? Strategies (see Appendix 1) provide much of the content driving the development and structure of this overarching HEO communication strategy.
- Development and discussion of a convergence approach for the HEO overarching strategy built around audience life-stages. This was accompanied with an abbreviated analysis of the structural and programmatic challenges associated with this approach.
- Preparing this draft overarching communication strategy document, designed to capture the thinking process, strategic directions and recommendations for future USAID supported SBCC interventions in the Western Highlands of Guatemala.

A next step, after review and approval of this draft overarching communication strategy, will be to develop a detailed implementation guide that provides specific steps and actions to take in creating the structural changes and SBCC programmatic interventions and materials associated with implementation.

## What is Social and Behavior Change Communication?

**S**ocial and **B**ehavior **C**hange **C**ommunication (SBCC) is the systematic application of interactive, theory based and research driven communication processes and strategies to address “*tipping points*” for change at the individual, community and social levels. (C-Modules, C-Change, FHI360, 2011).

The SBCC approach and principles signify the evolution from unidirectional Information, Education and Communication (IEC) approaches and include individual level Behavior Change Communication (BCC). SBCC also applies communication principles to advocacy and social and community mobilization strategies. SBCC views social and behavioral change as a product of multiple overlapping levels of influence, including individual, interpersonal, community and organizational as well as political and environmental factors. The approach aims to define tipping points for change, which - in complex societies such as Guatemala - are not always found at the individual level. A tipping point is an event or determinant that provides the energy to “tip over” a situation to change. (C-Change Project, FHI360, 2011).

## The C-Change SBCC Approach

C-Change is applying a social and behavior change communication (SBCC) approach to the capacity strengthening efforts in Guatemala in order to facilitate, capture and support the complex situation and desired changes the HEO programming is trying to address. SBCC, as interpreted by C-Change, has three key characteristics:

1. SBCC is an interactive, researched, planned and strategic process aimed at changing social conditions and individual behaviors

2. SBCC applies a comprehensive model to find an effective tipping point for change by examining: Individual knowledge, motivation and other BCC concepts, and social, cultural and gender norms, skills, physical access and legislation that contribute to an enabling environment
3. SBCC operates through three main strategies, namely advocacy, social mobilization, and behavior change communication.

In employing an SBCC approach, a systematic process is followed:

**Figure 1: SBCC Approach**

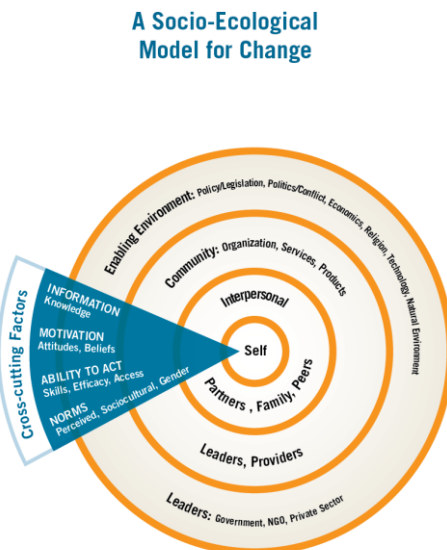


SOURCE: Adapted from Health Communication Partnership, P-Process Brochure, CCP at JHU (2003); McKee, Manoncourt, Chin, Carnegie, AGADA Model (2000); Parker, Dairymple, and Durden, The Integrated Strategy Wheel (1998); AED, Tool Box for Building Health Communication Capacity (1995); National Cancer Institute: Health Communication Program Cycle (1989).

Steps:

1. Understanding the Situation
2. Focusing & Designing your Strategy
3. Creating Interventions & Materials
4. Implementing & Monitoring
5. Evaluating & Re-planning

**Figure 2: The Socio-Ecological Model**



FUENTE: Adaptado de McKee, Manoncourt, Chin y Carnegie (2000)

Throughout this process, an ecological model is used for analysis, which examines several levels of influence to find effective “tipping points” for change. This model has two parts:

1. **Levels of analysis** are represented by the rings. The rings represent both domains of influence as well as the people representing them at each level.
2. **Crosscutting factors** in the triangle influence each of the actors in the rings.

The Socio-ecological model provides a framework for analyzing barriers and facilitating factors at different levels. This multilevel framework leads to more comprehensive and contextual programming by analyzing internal factors (such as self-efficacy), external factors (such as influence of family and peers and access to products and services), and indirect factors (such as

absence of supportive national policies) and how they are influenced by the cross-cutting factors (the triangle of influence).

**Figure 3: SBCC Strategies**



Based on the situation analysis, SBCC employs a mix of key strategies that go beyond and effectively complement individual level behavior change programming. These key strategies are:

**Advocacy:** to generate and reinforce political and social leadership commitment and raise resources in direct support to development actions and goals;

**Social Mobilization:** for wider participation, coalition building, and ownership, including community mobilization; and

**Behavior Change Communication (BCC):** for changes in knowledge, attitudes, and practices among specific “audiences”.

## 2. SITUATION ANALYSIS

Two levels of situation analysis were conducted in the development of this overarching communication strategy.

The first level was an analysis of the challenges and barriers to successful health outcomes. It examined specific priority health/education program interventions in FP, MCH, nutrition, HIV/AIDS and education. This analysis helped to identify specific challenges and their related and underlying causes in the targeted communities, research gaps, required changes and tipping points and possible theoretical underpinnings. This then informed the development of the four individual communication strategies including key audience segmentation, barrier analysis and specific communication objectives addressing them. All strategies include strategic approaches, positioning, key information, and illustrative channels for activities and materials specific to the audiences, health issues and regional context (see Appendix 1). Key elements from these analyses are highlighted and incorporated throughout this strategy document.

The second level of analysis focused on the institutions, partners, stakeholders and structures essential to developing an overarching HEO communication strategy. Structural issues such as these will be crucial in creating the paradigm shift in strategy from a focus on vertical health programming to a focus on horizontally linked programming packaged to appeal to audience life-stages.

### Situation Analysis I: Challenges and Barriers to Successful Health Outcomes in the Western Highlands

#### Family Planning Challenges

A relatively low CPR (28%) combined with high unmet need (30%) and poor birth spacing (62% less than optimal) among rural, indigenous women in Guatemala is contributing to unplanned pregnancies, increased health risks, and poor maternal and child health. The role of men,



mother-in-laws, and the church in decision making negatively influence a woman's ability to take action in reproductive health decisions. Limited access, poor quality health service, health provider biases, and poor client provider interaction further limit successful outcomes. Deep gender/cultural norms and a lack of information about family planning prevent women and men from seeking appropriate modern family planning services. In addition, early initiation of sexual activity, gender constructs, limited youth friendly services targeted to adolescents, and stigma associated with adolescents and family planning/contraceptives are contributing to high rates of unintended teenage pregnancy.

### **Maternal and Child Health Challenges**

Indigenous women in the rural highlands of Guatemala are giving birth at home without skilled attendants and no capacity to deal with an obstetric emergency. Complications from pregnancy and delivery result in a disproportional number of maternal deaths usually during delivery or the first week after giving birth. Babies are also highly vulnerable to morbidity and mortality. Chronic malnutrition of indigenous mothers, poor pre and postnatal care, limited transport options, and limited access to and capacity of obstetric facilities that can handle emergencies create structural barriers to successful birth outcomes. Hypothermia, macro and micronutrient deficiencies contribute to poor outcomes. A lack of knowledge/ability to identify danger and warning signs, for both mother and child, traditional roles of husbands and mothers in law in birthing, and poor community readiness to respond to emergency situations further complicate successful health outcomes. Breastfeeding is valued, but traditionally not immediate nor exclusive for the first 6 months. Inadequate weaning and complementary feeding practices, poor hygiene, and lack of potable water contribute to risk. Families often don't recognize danger signs and symptoms for children resulting in poor management of upper respiratory infections and waterborne diseases. Limited access, poor quality health services, fear of bad treatment and a lack of confidence in the health care system create barriers to successful client health provider interactions.

Deep gender/cultural norms and a lack of planning and birth preparedness within families and communities contribute to the high maternal mortality rates; women are not empowered. Chronic malnutrition of the mother and a health care system (designed more around the needs of providers rather than consumers), that doesn't respond to the clients in a contextually or culturally appropriate way, further increase the vulnerability of the mother and child's health outcomes.

### **Nutrition Challenges**

Rural, indigenous women and children under two have high chronic malnutrition rates due to structural and behavioral factors resulting in higher infant and maternal mortality and morbidity rates, low competitiveness, low productivity and high rates of stunting.

Geographical location, community structure and leadership, family members, and traditional practices influence the nutritional status of women and children. Malnutrition during pregnancy combined with poor initiation and exclusive breast feeding rates and limited access to nutritionally optimal complementary foods negatively impact the critical 1,000 day space where nutrition is essential to health and has a life-long impact. More specifically, grandmothers, husbands and midwives reinforce traditional customs and beliefs, which lead to poor nutrition outcomes. Fathers purchase and decide the family foods, but are not aware of

the link between food and nutrition. Community based health services and health posts are not properly trained in nutrition counseling and delivery of health services are complicated by culturally inappropriate services. There is a general lack of coordination amongst local leaders, schools, and churches to address nutrition issues. Agricultural and food value chains have yet to be fully engaged in enhancing the nutritional value of their crops and foods, in part because of a lack of consumer demand and financial and technical support to enter new markets.

Structural causes such as inequality and exclusion, normative gender roles and relationships, existing concepts and understanding around nutrition (prevention vs. treatment) and the gaps between agriculture and nutrition and health and food, limit the progress towards better nutritional outcomes.

### **HIV Challenges**

Most at risk populations (MARP) and people living with HIV/AIDS (PLHIV) clients are reluctant to attend public health clinics because of the stigmatizing and discriminating treatment they receive. This reinforces the clients' low self-esteem and results in poor health monitoring and higher morbidity and mortality rates. Health care providers are poorly trained in the area of HIV/AIDS and client-oriented services, and are unaware of the relevant human rights issues. This situation blocks access to the continuum of care for each of the populations considered MARP as well as for those who are living with HIV/AIDS.

Local community leaders, churches and schools place a low priority on quality HIV/AIDS services. Local NGOs representing MARP and PLHIV work in prevention activities and provide volunteer staffing in the local health offices, and act as a link between the their members and service providers, promoting better services in the 8 regions most affected by HIV/AIDS.

Social norms, prejudices, cultural barriers towards the sexual behavior of MARP and PLHIV and a lack of political will at the national level contribute to continued stigma and discrimination in spite of protective laws and regulations.

### **Education Challenges**

Education is undervalued and parents and communities don't support or demand for improved education, both inside traditional schools and within the larger community. There is limited to no access to books/libraries and other community resources that would expand learning opportunities beyond the classroom. Parents/families are not engaged in schools and learning – and little education/learning takes place in the home or in places other than the schools. Inconsistent and poor quality of teaching/education in the primary schools leads to low literacy rates and high dropout rates/discontinuation before completion/graduation. In particular, there are limited opportunities to practice and improve literacy, including health literacy, for adolescents within the immediate community.

## **Situation Analysis II: From Vertical Health Programming to Horizontally Coordinated Life-Stage Approaches**

### **Problem Statement:**

HEO currently supports critical health initiatives in Family Planning, Maternal & Child Health, HIV/AIDS, Nutrition and Education. In response to best practices, the Global Health Initiative and Feed the Future strategic frameworks, HEO is moving from the current structure of

coordinated vertical programs with their own specific SBCC strategies, objectives and outcomes to a more integrated approach. Coordinated vertical structures do not fully exploit the interrelated nature of the health issues and leave open the potential for duplication of effort, inconsistency in messages, gaps within and across programs, and limited opportunities for taking a more comprehensive approach. Instead, programs are currently competing for audience attention while their content is not always context appropriate or relevant to their current life cycles. As such, in conjunction with developing comprehensive SBCC strategies in each of the health/education initiative areas, HEO wishes to develop a communication strategy that provides a more cohesive approach to SBCC across coordinated HEO interventions.

Developing and implementing this overarching HEO communication strategy will require structural and operational changes within HEO and its partners; new levels of collaboration/cooperation across key stakeholders in government, the health service delivery sectors (public, NGO, and private) and community organizations/structures; and additional resources and technical support associated with implementation. This will likely lead to additional linkage activities within the HEO teams associated with planning meetings, reviews, collaboration, and making minor modifications and adjustments to current plans and activities.

#### **Barrier Analysis:**

An integrated approach is currently not in line with the structural realities in the HEO programming as well as in the Ministry of Health (MOH). Funding streams, management structures, indicators, and reporting requirements tend to be structured along vertical health initiatives which tend to result in vertical implementation of programs. For most of the partners and stakeholders, their mandates, rewards, recognition, and reinforcement are linked with their vertical initiatives and indicators. Project cycles and the inevitable changes in staff and leadership within USAID and the Government of Guatemala (GoG) including the MOH, create continuity challenges in shifting paradigms that require longer term horizons and planning

#### **Additional Findings from an Internal SBCC Capacity Review**

A 2010 consultancy of HEO SBCC capacity identified structural challenges to implementing SBCC programming with current USAID partners. A 2010 (Coe, 2010) analysis of BCC and SBCC programming in Guatemala identified four gaps in SBCC programming:

- SBCC structures at the regional level need to be strengthened – cost effective approaches need to be implemented:
  - Coordination committee
  - Common technology platform and integration
  - Monitoring and evaluation
  - Integrating health and education
  - Key personnel – communication
  - Key issues
  - Communication mix
- Cooperating Agencies are not transferring the art & science of SBCC to Guatemalan institutions. There is a need for greater leadership from MOH, especially in infant health and nutrition, and infant and maternal mortality. This lack of MOH capacity has led to difficulties in implementing national SBCC campaigns.

- Health care personnel don't speak the language of the people they serve, idiomatically or culturally.
- Cooperating Agencies need to improve their strategies when working with the media to address key issues and to improve their advocacy strategies for working with policy makers as an audience. Current print media strategies fall short and partners need to work with journalists to create appeal, both rational and emotional, that is easily understood, and provides viable policy options within the Guatemalan context.

Additionally, the following gaps were identified in the SBCC services in the Western Highlands region of Guatemala:

- a) Lack of a coordinated SBCC approach across USAID and national health programming
- b) Limited decentralized SBCC planning at the municipal and district levels
- c) Most of the communication efforts fall in the category of information education and communication and don't apply the mix of participatory methods and motivation necessary for the behavior change process.

The overarching communication strategy and the implementation guides will be addressing these gaps.

### 3. STRATEGIC APPROACH

The overarching SBCC Strategy is built on the concept of an orchestrated convergence of key health interventions around the specific life-stages of our Western Highland families; an approach which recognizes that specific health information and services are needed at different times, based on a particular stage of life and lifestyle. Convergence means that at a specific life-stage (for example, newly married couples) SBCC activities and programming will cluster and converge around an appropriate set of continuum of care needs, at the individual, family, community, service delivery and social political levels.

Under this strategic approach, the family is more than the object of health programs. It becomes the primary force pulling the programs forward. Over time, life-stage driven public demand will be the engine that drives program growth and the sustainability of interventions.

Three guiding principles will help shape this convergence strategy around life-stages:

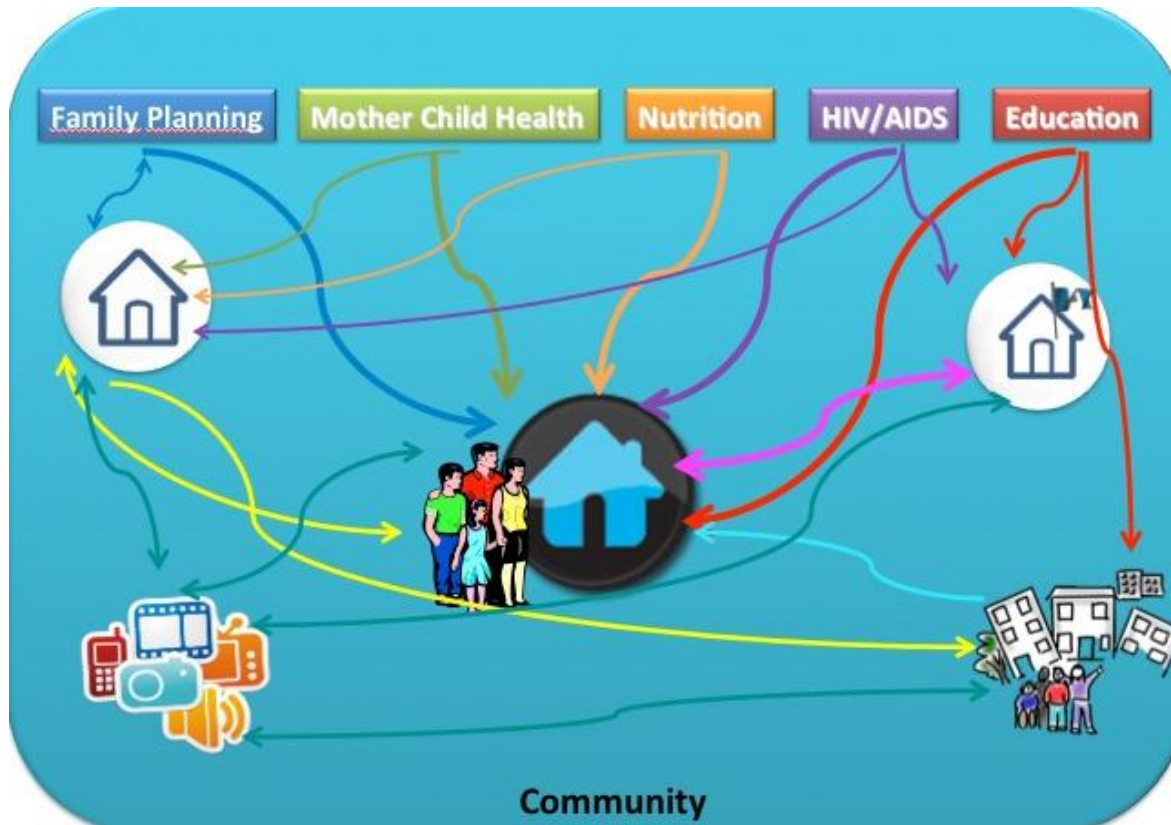
1. Households and communities are the drivers of health and health outcomes, both good and bad. What they do is critical to any immediate and longer range/sustainable success.
2. Convergence and integration is built around health information needs, and the timing and ability to take health related actions at the most appropriate times; tied to the specific life-stage. This requires more than information and relies on more than the individual; it includes an enabling environment that supports taking action.
3. Convergence and integration will include a focus on "systems", which supports changes at all levels and across all sectors. This includes health care delivery systems, community-

based support systems, and government and donor support mechanisms, along with changes in gender constructs, perceived cultural practices, and current social norms.

At the operational level, this convergence approach will provide an organizing platform around which previously independent components can come together to create a collective sum that is greater than its parts. Ideally, this will be accomplished through a more strategic alignment of existing resources and partners, as opposed to creating entirely new structures requiring new resources. For example:

1. Integrating components of the 5 health/education interventions will help ensure consistency of information delivery; create efficiencies and economies of scale; avoid confusion associated with inconsistent and contradictory messages; limit duplication of effort and materials; and make it easier for clients, consumers, and families to act.
2. Integrating health content around specific life-stages provides a common anchor or positioning – “The Healthy Family/Community” – while ensuring specific/critical health messages are not lost. It can help identify gateway behaviors and cluster approaches as potential predictors of change.
3. Integrating interventions across sectors (public, NGO, and private) will build on the comparative advantages of multiple partners, each playing to their unique strengths based on their roles and relationships with the various life-stages. Given USAID’s focus on the Western Highlands, inter-sectoral strategies can create opportunities for learning, under a learning model that tracks process and health outcomes, which can inform expansion in the highlands and the larger national programs.
4. Integrating communication tools and approaches will lead to stronger and more strategic links across communication channels including mass media, local media, commercial marketing, community/groups interactions, interpersonal communication, and health and education counseling. This can lead to improved integration on the supply side (health delivery systems, food/nutrition systems) and the demand side. It can also lead to better integration of national campaigns and local initiatives around life-stage needs and not individual health issues.

## Strategic Alignment Under the Convergence Strategic Approach:



This illustration of the various interventions and the lines of interaction and SBCC communication suggest that most components of the interventions work in the same communities, through the same health centers, targeting the same households. Together they show the many opportunities for convergence and integrating the multiple health issues around key life-stages, using the life-stages and households and communities as an organizing principle.

Aligning SBCC interventions around life-stages will require changes in the alignment of structures, programs, and systems to maximize impact, reinforcement, and potential sustainability of health outcomes. True convergence and integration goes beyond coordination and information sharing. It requires a “center of gravity” along with ownership, commitment, and full participation of many critical players. Partners and stakeholders must come to realize that aligning with and being part of the convergence strategy strengthens their role and the role of their programs, and does so without the need for additional resources, or asking for sacrifices, compromise, and giving things up. We anticipate that many of these structural changes will take time and careful negotiations, and will likely be led by “early-adopters” to gain momentum before other organizations and partners come on line.

A future implementation guide will address the process and steps to bring this about. At this stage in the design process, the strategy identifies the key components for convergence, along

with the overlaps and gaps needed to be included in a robust SBCC program. These include the following:

### **Convergence within Guatemala and the Western Highlands:**

The primary geographic focus for this SBCC strategy is in the Western Highlands, an area consistent with USAID program investments, where current health statistics of the underserved population are well below the national averages and unmet need is greatest.

Focusing efforts in the Western Highlands presents unique challenges and opportunities. According to the World Bank, Guatemala has one of the most unequal income distributions in the hemisphere. The wealthiest 20% of the population consumes 51% of Guatemala's GDP. As a result, about 51% of the population lives on less than \$2 a day and 15% on less than \$1 a day. Guatemala's social development indicators, such as infant mortality, chronic child malnutrition, and illiteracy, are among the worst in the hemisphere. (Source: <http://www.state.gov/r/pa/ei/bgn/2045.htm>)

The area is known for its rugged topography and limited infrastructure; creating challenges associated with accessibility, poor roads, and frequent natural disasters including tropical storms, floods, mudslides, earthquakes and volcanic activity. It is home to the indigenous Mayan people, with deep seated cultural values and traditions, and a strong ethnic identity that is equally highlighted and discriminated against, and too often victimized by stigma and cultural bias. It is subject to external politics and influences in the National Government, and influenced by internal politics and local leaders. And perhaps most relevant, it has a disproportional share of health issues and development problems, lagging behind the national statistics and data. In large part driven by the lack of investments, limited accessibility of roads, poor delivery systems for health, food, and related commodities, and poor infrastructure including availability/access to safe water, basic hygiene, education, information, and basic health services.

Yet, these challenges also present opportunities. The area is geographically and culturally defined, providing an opportunity for focus. Past investments have been inadequate in moving the key indicators when compared to national trends, providing an opportunity for innovation, experimentation, and the creation of learning models in a learning environment. Key partners and local stakeholders can be empowered to identify, design, and measure new/different interventions, with an eye towards expanding institutional learning and regional outcomes. Properly managed, the convergence strategy can be a mechanism for driving change, aligning new types of partnerships, involving traditional and non-traditional actors, and providing a learning and doing platform at all levels of engagement. While steeped in culture and tradition, the area is not in total isolation. Outside influences from the media, migrant family members working outside the region and returning to visit, growing cell phone access, and generational changes are leading an evolution of change that provides potential insights for health and development. Positive deviants (those families making all the right health decisions, despite the surrounding environment) are growing in numbers and in some cases are beginning to reshape norms around certain health statistics. There is little to lose, much to learn, and much to gain, allowing for the opportunity to generate excitement and interest around the design and implementation of the SBCC interventions.

Convergence activities will seek to align and engage with the key actors and interventions operating at the policy, community, and households levels, who are currently working to address and/or influence the health and development needs in this same region. These include:

#### **Funders:**

- Within USAID (Health, Education, GHI, FTF, and across other USG supported initiatives CDC, USDA, HHS);
- Across USAID Partners (CAs and contracting partners), and
- Across other Donors (UN agencies, etc.)

#### **Governments:**

Across GoG political governance at all levels (National, Department, Municipal, and Local); and Health and Non-Health Ministry Sectors: Ministry of Health, Education, Agriculture, Food and Livestock, Social Development (a new Ministry coming in with the new government) Secretariat of Food Security and Alimentation (SESAN).

At the municipal level, Municipal Development Council (COMUDES) is a council of up to 20 representatives of public entities represented in the community;

#### **Civil Society & Community Groups:**

- At the regional , community, and social level including: NGOs, churches and religious organizations, “markets”, community networks, Community Development Councils (COCODES) are a community structure created to increase participation in community planning and to monitor public entities. COCODES are part of a national network of development commissions that operate at various levels: municipal, departmental and national; formal and informal social networks.

#### **The Health Care Delivery Systems:**

- Across public health care facilities and providers at all levels of service delivery (hierarchy of access/care);
- Across urban, rural, community outreach workers and social workers; and
- Across relevant private sector providers.

#### **Communication Strategies, Channels, and Tactics:**

- Across mass media interventions and channels, including strategies, agenda setting, role modeling, creating social norms, and in messages, campaigns, existing programs, new programming, and related program materials;
- Across community based media and community participation interventions associated with social, religious, education, markets, and development groups and programs;
- Across interpersonal communication and counseling channels, including life-stage oriented counseling tools, education materials, in-clinic media, schools, and in market based, religious, and social settings; and



- Within and across advocacy programs at the national, regional, and community level and in conjunction and use of the growing influence of new information technologies including cell phones and social media access.

### Households:

- Household members include key life-stage audiences (young mothers, fathers, and adolescents); and
- Key influentials of life-stage audiences including mother-in-laws, blood relatives, and other social influentials.

For SBCC purposes, the health service delivery system in the Western Highlands is a critical stakeholder for convergence throughout the sector; including the facilities at all levels and rural, community, outreach workers, and volunteers. The starting point for making this transition is a long standing model of vertical interventions, which has resulted in inconsistent capacity across the various health issues and departments, driven in part by funding and national health priorities. The health care system is emphasizing a new approach that is based at the municipal level. This devolution provides an excellent opportunity for greater integration of services including facility based and those associated with outreach into the community. It also provides opportunities for improved alignment with other community/social structures including groups in education, agriculture, religion, and the social development sectors.

Maximizing the opportunities for aligning these key players and interventions will help create the more enabling social, policy, community, and health care delivery environments within which families will be able and more empowered to make and take better health decisions and actions.

## 4. AUDIENCES

A fundamental paradigm shift in the over-arching strategy is to move the driving focus from the health subject to an individual and a family's life-stage; around which relevant health subjects converge. This moves moms, dads, and families from being recipients of health information and advice to being the drivers and key actors as health information seekers and decision-makers. It requires their inputs into shaping the interventions in ways that are culturally relevant and appropriate and recognizes their role is using our interventions in ways that help them in problem solving and addressing/managing their own family health needs. These needs change over time and across the various life-stages. All of which adds to the importance and dimensions associated with the identification and segmentation of these key audiences within the life-stage setting.

There are many ways to define and segment audience life-stages; typically based on demographic variables (age, sex, urban/rural geography, marital status, income, education, etc.) and often combined with psychographic or lifestyle variables (culture, ethnic background/traditions, purchase behavior, etc.). In developing the strategy, the following audience life-stages were identified and considered:

## Life-Stages and Relevant SBCC Health Information Needs:

### Youth (adolescents, unmarried)

- Risk behaviors, life skills, nutrition

### Young Marrieds (spacers, 0-2 children)

- Spousal communication, MCH, FP, nutrition including during pregnancy, safe delivery, optimal breast feeding and complementary feeding practices, optimal spacing, and adoption of modern contraceptives for appropriately spaced births

### Older Marrieds (limiters, school age children)

- Spousal communication, MCH, FP, nutrition including during pregnancy, safe delivery plans, optimal breast feeding and complementary feeding practices, optimal spacing, and transitioning to limiting family size and longer term/permanent contraceptive methods

### Children (age 6 up to pre-teen)

- IMCI, nutrition, hygiene

## Primary Target Audience – Life-stage Segmentation

HEO health priorities and investments primarily cluster around two of the four identified audience life-stages, leading to the identification of the following two primary life-stage audiences: “young marrieds” and “adolescents”. An illustrative description and example of how the various health issues align for each of these life-stage audiences are outlined below. These descriptions and the alignment of health issues and convergence of interventions will be a starting point for formative research that will help to further define and shape the overarching interventions.

### Young Marrieds/Couples (0-2 children) Living in Western Highlands

#### **An illustrative Continuum of Health Information/Action Needs – Direct Convergence of FP/MCH/Nutrition/ Interventions; Indirect Convergence with Education & HIV**

Young marrieds/couples are at a life-stage defined by change, especially as they move from single individuals to joined couples. This is an opportunity to address gender constructs and practice good husband-wife communication as they plan for their futures, determining how many children to have, how best to raise a family and provide for their children, and what kind of future can lie ahead. Relevant interventions will include the integration of family planning, maternal child health, and nutrition; with emphasis on empowerment, self-efficacy, and changing social norms/gender constructs for making and taking appropriate health decisions/actions within a more enabling environment that facilitates and supports their decisions and actions. An illustration of these components within this life-stage can include:

1. **Spousal/Partner Communication** – Working together to plan your future...  
Planning your children – how soon, how many, how to plan regarding health, economics, and quality of family life.

2. **Safe Pregnancy** – Being pregnant is a special time...  
Mother's health and nutrition; pre-natal care.
3. **Safe Delivery** – Ensuring healthy moms and babies...  
Giving birth at a trained facility; planning for emergencies (4 delays); newborn care.
4. **The Best for Your New Baby** – Making a healthy start in life...  
Early initiation of breast feeding; exclusive breast feeding for the 1st 6 months; optimal complementary feeding; preventing and managing health problems – immunizations, good nutrition, hygiene/safe water, respiratory infections, diarrhea.
5. **Spacing for Optimal Health and Development** – Improving quality of life...  
Choosing the right contraceptive method; allowing time for the mother to recover; allowing time for the child to develop.
6. **Living a Better Family Life** – Staying healthy and active in the community...  
Hygiene & safe water; environmental health; good family nutrition; enjoying the family – school, reading at home, making the most of the health system.

### Target Audience – Adolescents (Youth, Unmarried) Living in Western Highlands

#### An illustrative Continuum of Health Information/Action Needs – Direct Convergence of FP/HIV/Nutrition/Education Interventions and Indirect Convergence with MCH

Adolescents are at a life-stage of learning, especially as they move from childhood to young adult. They are fully engaged with family, but also establishing their own independent relationships with peers and community influentials/leaders (schools, churches, social venues) and they often rely on and are influenced by media, social interaction, and newer technologies. Relevant interventions will be those that offer opportunities to develop life skills that result in better decision making, risk mitigation, and better quality in day to day living and will likely include the integration of health and education, with emphasis on prevention and empowerment and in a more supportive environment for making and taking appropriate health decisions.

1. **Life Skills:** Learning, negotiating, and participating in the family and community...  
Learning: reading and learning outside of and inside school about healthy living including reproductive health, hygiene, preventing infections, taking care of siblings, and good nutrition.  
Negotiating: communicating with peers, communicating with parents, working together to protect health and well being, and to plan for a better healthier future.  
Participating: playing an active role in the family in helping/supporting emergency birthing plans, safe water and hygiene practices, food preparation and caring for siblings; taking care of your own health.
2. **Risk Behaviors:** Protecting health and being prepared for the future...  
Protecting against early/unintended pregnancy, HIV/AIDS, poor hygiene and nutrition and knowing and having access to help, when needed.
3. **Good Nutrition:** Knowing and making smart food choices for better living...  
Buying/eating the right foods (diet diversity, fortified staples, healthy eating/nutrition) and following optimal hygiene and nutrition practices when feeding younger siblings.

### Secondary Target Audiences – Key Influencers of the Life-Stages

While the life-stages represent the primary target audiences, they do not exist in isolation of other critical influences including members of the extended family, neighbors, community leaders, religious leaders, social networks and groups, health care providers, markets, schools/teachers, national and local governance/leaders, and the media. These secondary audiences are identified in the attached appendices, along with strategies that incorporate their roles in creating change. An integrated approach to engage and activate these audiences will be developed and delineated in collaboration with HEO staff and partners, as part of the next steps in the creation of the overarching communication strategy implementation guide.

## 5. SBCC DESIRED CHANGES & INTERVENTIONS

### Priority Areas and Tipping Points for Social Norm and Behavioral Change and in the Overarching HEO Communication Strategy:

While the situation analysis outlined the current health challenges and barriers, this section looks at the desired changes and key tipping points for those changes to take place. More details regarding the desired changes and tipping points for each of the health interventions can be found in the appendices. The section also highlights desired changes and identifies tipping points within institutions and structures in order to create a more enabling environment for the implementation of the overarching strategy.

#### Desired Changes in Family Planning:

Newly “married” couples discuss and share ideas and plans for having children, including when, how many, and how best to space between births. These discussions are shared with key family influentials, including mother in laws.

Women are familiar with modern methods and believe FP is important, widely practiced, and socially acceptable. They understand and value birth spacing, seeking to optimally space between children as a way of providing the best nutrition and developmental support, and future. This belief is supported by their husbands, families, and the community at large.

Women have the confidence to discuss family planning needs and options with providers, and to select the method most appropriate for their needs.

Adolescent girls and boys understand basic reproductive health, and know how to avoid and protect themselves against unintended/unwanted pregnancy. They have access to appropriate information through youth friendly health centers, community organizations, and local NGOs.

More couples use modern FP methods and are successful in optimally spacing between births.

#### Family Planning Tipping Points:

- Better communication between husband and wife
- Better client oriented services

- Better informed and more empowered youth

#### **Desired Changes in Maternal & Child Health:**

Pregnant mothers and their husbands and extended family members know the warning signs of complications during pregnancy/delivery and have an emergency plan to get to an appropriate facility, should complications warrant it.

Mothers look for and use skilled birth attendants and/or skilled facilities for routine prenatal care, birth, postnatal care, and support.

Mothers are empowered to seek and receive counseling and understand and engage in healthy practices such as exclusive breastfeeding, giving colostrum to her baby within the first hour of birth, kangaroo mother, proper birth spacing, complementary feeding, safe hygiene, and receiving appropriate vaccinations on schedule. They are engaged with and supported by their husbands, mothers in law, and appropriate family and community members.

#### **Maternal & Child Health Tipping Points:**

- Family members and community leaders able to recognize danger and warning signs in pregnancy, postnatal care and plan for emergency situations
- Health care providers offer consistent and positive client oriented counseling and services for maternal child health needs, using a client-centered approach
- Advocacy results in increased facility-based delivery

#### **Desired Changes in Nutrition:**

Mothers understand and practice optimal breastfeeding (immediate initiation, exclusive breastfeeding for 6 months, and continued breastfeeding with complementary foods through two years of age) and are encouraged, supported, and reinforced by their husbands, mothers in law and by the community. Mothers introduce timely and nutritionally appropriate complementary foods at weaning and beyond (appropriate foods, variety, and volume of foods).

Mothers and their families understand and practice improved nutrition at home, with special attention to:

- optimal maternal nutrition during pregnancy and lactation – including rest and eating the right foods during pregnancy and breastfeeding;
- appropriate nutritional care of sick and severely malnourished children;
- adequate intake of vitamin A, iron, folic acid, and zinc, especially for women and children;
- adequate intake of iodine by all members of the household.

Parents and health providers expect taller children and understand stunting results from poor nutrition.

Western Highland families/consumers actively demand and have greater access to affordable and nutritious food options in the community and market place. Readily available information motivates and reinforces their choices for more nutritious foods.

Adolescent girls and boys understand the value of good nutrition and actively participate in family practices of planning, buying, and preparing more nutritious meals.

#### **Nutrition Tipping Points:**

- Mothers get appropriate foods and time to rest during pregnancy.
- Mothers understand and practice optimal prenatal nutrition and breastfeeding, and are supported by husbands, mothers-in-law and by the community.
- Indigenous consumers actively demand and have greater access to affordable and nutritious foods including complementary food options for children ages 6 -24 months.

#### **Desired Changes in HIV/AIDS:**

Stigma and discrimination levels are reduced between MARP and PLHIV and the health care providers, local community leaders, churches, and schools that are involved in the continuum of services, from prevention to care.

MARP and PLHIV gain confidence and practice more assertive health seeking behaviors.

Traditional male gender norms shift towards more egalitarian norms, further reducing stigma.

Adolescents understand HIV and are aware of and follow preventive practices. As they learn more, they work to reduce stigma within their immediate communities and households.

#### **HIV/AIDS Tipping Points:**

- MARP and PLHIV exhibiting assertive health seeking behavior
- Proactive multi-sectoral networks reduce stigma while better meeting service needs
- Adolescents reduce risk behaviors and follow preventive practices
- HIV policies ensure funding of health costs

#### **Desired Changes in Education:**

Parents and the community value and demand better education in their schools.

Opportunities for learning are created beyond the classroom, led by greater emphasis on reading and greater access to books, publications, and health literature in the community through libraries and community organizations.

Literacy rates improve and drop out/discontinuation in schools decline as schools improve their quality of teaching and communities become actively involved.

#### **Education Tipping Points:**

- Parents/communities active engagement in education improves learning, school performance, quality of education materials, and improved investments in schools.

- Increasing access to books and promoting reading (outside of school) reinforces values of education and expands learning beyond the classroom.
- Adolescent's access to reading and information includes relevant and culturally appropriate health information.

## Desired Changes in Institutions and Structures and their Tipping Points

Health care providers offer consistent and positive client oriented counseling and services, building trust and providing support to positive family planning, maternal child health, and nutrition practices. They use culturally appropriate language and counseling aids; listen and encourage client questions, and are prepared to help clients understand the continuum of health information and counseling needs across pregnancy, safe delivery, optimal nutrition, optimal birth spacing, and related life-stage health interventions including management of acute respiratory infections, water borne illnesses, growth monitoring, and early signs of malnutrition.

Traditional birth attendants are trained in and practicing safe delivery methods, and include kangaroo mother care, treatment of parasites, appropriate follow-up care and identification of risk factors and signs of danger for mother and child.

Doctors openly talk about modern FP during office visits, along with advice on pre and post natal care, immediate initiation and exclusive breastfeeding practices, appropriate complementary feeding, optimal nutrition for adolescents, pregnant moms, babies, and young children, and healthier living for young families.

The quality of HIV care is improved through the enhanced counseling and interpersonal skills of health providers, reducing bias and stigma, and better meeting the needs of PLHIV, FSW, MSW, transgender, and gay people.

Community organizations support and encourage better health at the household level. Schools encourage reading outside the classroom, including reading about health. Churches promote nutrition, hygiene, and other health practices, directly engage adolescents in health related issues around the community and home, and support emergency birthing plans at the community level. Local NGOs incorporate and support health initiatives in their missions and local programs/interventions. Healthy families and healthy communities becomes everybody's business.

Community leaders understand and openly support and endorse family planning programs to improve quality of life and health of families. They lead and organize emergency birthing plans for the community, including transport to an appropriate facility in case of obstetric emergency. They encourage and support exclusive breastfeeding for the first 6 months. They facilitate access to more nutritious foods for families, pregnant women, and children 6-24 months. They take a leadership role in helping to reduce stigma associated with HIV, and support local health centers, NGOs, and community groups working with MARPS and PLHIV. Their community designed SBCC programming is updated on an annual basis, keeping the progress towards better family and community health outcomes visible and relevant to the community. They become champions for healthy families and healthy communities.

Proactive multi-sectoral networks at the local level (local health office, local NGOS representing MARP and PLHIV, IGSS, civil society representatives (firemen, police)

are created and help to mobilize the community for improved access to prevention and care services.

National political leaders and related Ministries are encouraged to invest more in health and nutrition, including: expansion of facility based births/deliveries: improved integration of health services at all touch-points in the health care delivery system: and promoting and supporting enhanced agricultural and food value chain markets for nutrition. Community, health, and business leaders are motivated to act and to promote improved health and nutrition through community channels and markets.

The GoG develops and maintains national HIV/AIDS policies, regulations and awareness-driven activities that create a supportive environment for quality HIV/AIDS services in the 8 regions of Guatemala that have reported HIV/AIDS cases.

Schools improve the quality of teaching/education in primary grades with pressure and support from their communities; improving learning/literacy and decreasing drop outs; and incorporate more health related topics both in school and in community learning opportunities.

### **Institutional Tipping Points:**

- USAID HEO officers and partners plan, prioritize, manage, recognize and reward integrated interventions and achieve synergies and economies of scale through: consolidating research (formative and monitoring/evaluation); engagement of local/community based stakeholders/partners; future program interventions; and designing, producing, and evaluating SBCC advocacy and communication materials, messages, and channels.
- Government of Guatemala counterparts advocate for and invest in improved nutrition, facility based deliveries, proactive multi-sectoral networks that de-stigmatize and address HIV service needs; and community involvement in schools and education. They influence relevant ministries to align around the priority health agendas in the Western Highlands and at the national level.
- Public and private/NGO health care delivery and services change their structural orientation and approaches to create more culturally sensitive and appropriate counseling and services across a fully integrated range of health initiatives clustered around the needs of young families and adolescents in the Western Highlands. They integrate health information and clinical services and improve client interaction across facilities, outreach, and counseling and they engage with community organizations, churches, schools, markets, and other local institutions to expand the reach and effectiveness of healthy behaviors and practices.

### **Key Message Strategies in the Overarching Communication Strategy:**

A preliminary scan of health related materials and messages suggests a wide range of existing printed materials providing varying levels of focus, technical depth, and audience appeal, and identified several technical inconsistencies in health content/information. For example; family planning materials range from a narrow focus on individual methods to a broader focus on method choice, with some incorporating additional health information around the family planning focus. Within these materials, spacing advice may be different, with some advocating for 2 years, some 3 years between pregnancies, and other 3 years between births. A more thorough review will be conducted as part of the inputs to the development of the implementation guide.



Current materials and messages reinforce the recognition that the vast majority of programs are driven by the health issue relevant to the producer; and then targeted to the end users or to health providers as counseling tools/aids. As a collection there are as many differences as similarities. Other than in individual “sets” (e.g. family planning methods) they were clearly not developed as a part of a larger whole or continuum designed to address a continuum of health needs around a specific life-stage. This presents many challenges ranging from what to do with the current stocks of recently produced messages/materials, to how to ensure consistency of key content and repackage information into an integrated format that addresses the range of health information needs from the life-stage perspective.

Specific health messages and targets are delineated in the appendices. The following strategies and guidelines are recommended as the implementation process moves forward.

- Bring the technical experts together to identify and reach consensus on the critical health content and messages relevant to the life-stage health issues. Use this consensus to develop a technical tool for all partners to use in their SBCC activities at all levels. Create a mechanism within HEO and/or the partnership which allows for quick but accurate review of the technical content as part of the formal approval process.
- Using audience consultations, formative research, and participatory approaches; explore concepts, approaches, images, and language that resonates with the audiences and their life-stages within the context of culture, traditions, and constructs of the Western Highlands; and that move the goals of the interventions forward. Use this to develop a context specific set of interactive intervention strategies that can guide partners and stakeholders in the development of future SBCC interventions, support materials and messages.
- Recognizing the structural and institutional changes required in implementing the overarching convergence approach and integrating health around audiences and their life-stages; develop SBCC interventions, support materials, messages, and specific to facilitating institutional/structural change. This will likely involve a combination of advocacy, interpersonal constructs and communication, technical support associated with change management, “how to” materials, and a shared learning based knowledge management program.
- Using the strategies above, collectively explore ways in which current stocks of materials might be used and combined in a fashion that begins to pave the way for a more integrated SBCC approach. As convergence and programs advance, orchestrate and develop new and more appropriate materials, programs, messages, and interventions (interpersonal, counseling, community, local media, mass media, and advocacy oriented) to drive, support, and reinforce positive health changes and outcomes.

### **Key Channel Strategies in the Overarching Communication Strategy:**

Specific channel strategies are identified and delineated in the appendices. These include:

- A combination of mass media, local media, community interaction, interpersonal communication and counseling, and market-based channels that cut across broadcast, print, and social media, targeted around life-stage couples and adolescents and their influencers;

- A combination of advocacy channels including meetings, presentations, events, interpersonal exchanges, and media advocacy targeted around national and local leaders and designed to influence agenda setting, investments, and structural change in health services delivery, birth preparedness, HIV services, nutrition and nutrition markets/value chains; schools, and ministerial and local political alignment around the critical health issues in the Western Highlands; and
- A range of internal organizational channels (similar to business-to-business channels) including media advocacy, meetings, presentations, events, internal channels (employees, members, etc.) capacity building workshops, interpersonal exchanges, mentoring, and technical assistance and tools designed to engage key community organizations (NGOs, schools, churches, community groups, and agriculture, food, health and life-stage related businesses) in supporting and advancing healthy families and communities. A subset of these channels will be targeted specifically to the health delivery system, to support change management and organizational development across facilities, providers, counselors, and outreach systems specific to the structural integration of health services around the key life-stages.

As convergence gets underway and new program/campaign materials and messages are developed, the channel strategies will evolve to incorporate integrated topics, leverage economies of scale, and maximize message impact. For example: this may include entertainment education programs that focus on modeling new gender constructs, highlighting healthy choices and behaviors across the life-stage, changing social norms, and empowering families to do more and expect more in determining their own health. And it may link this with and rely on reaching life-stages with integrated health information and opportunities for taking health actions using cell phones, social networks, community organizations and community based problem solving with interpersonal communication channels such as peer to peer, family to family, and community to members. This convergence of channel strategies will be explored during the development of the implementation guide.

## 6. STRATEGIC CONSIDERATIONS & POSITIONING

There are many avenues/options open to planners wishing to implement this convergence strategy; ranging from revolutionary (a complete overhaul of current SBCC systems and programs under a fully branded and highly orchestrated convergence banner) to evolutionary (aligning systems and programs over time, starting with the “low hanging fruit and early wins” of alignment, and building convergence from the program up). Given the current environment of upcoming changes in the post-election government, limited and committed resources within the USAID portfolio, and planned procurements associated with the Global Health Initiatives and Feed the Future; planners will want to take a more evolutionary approach in developing the implementation guide and program plans and in implementing the key components of the strategy.

Regardless of the approach, the convergence strategy requires a carefully crafted and well positioned packaging of the essential health interventions around the core life-stages.

### Positioning & Branding Strategy

A branding strategy will help in providing and driving the connections and connective tissue between and across the integrated SBCC interventions, messages, and materials. Audiences should experience each individual piece (i.e. leaflet on FP methods, community event on nutrition, etc.) and every life-stage health related experience (i.e. health center visit, outreach event, health counseling, etc.) to be connected and to be part of a whole that, when taken together, is how families in the Western Highlands make the right choices for their children and themselves. While creating this alignment by organizing interventions is the first step, making the connections clear and explicit, and finding ways to make these connections easily understood in the minds of the families and communities, is more effectively facilitated and achieved through a consistent and relevant branding strategy. Specific recommendations, guidelines, and illustrative examples in developing the positioning and branding strategy are outlined below:

Using formative research, develop a “branding strategy” that easily identifies, links, and frames the health interventions around the values and perceptions of the life-stage audiences.

Consider the following guidelines when developing the brand and positioning. Create a brand and positioning that audiences feel is:

- Aspirational, appealing, achievable, simple, memorable, easily understood and communicated, with a sense of identity and shared belonging (normative) and culturally relevant
- Broad enough to support all and future relevant health interventions
- Flexible enough to use as a stand-alone overarching framework and/or as an aligning signature on the individual health interventions and program materials
- Simple and inexpensive to adapt and apply across media, materials, institutions, events, and other applications. The brand must maintain image/communication integrity across a wide range of application ranging from higher end broadcast media, to low cost one-color leaflets, to counseling aids, from large posters to small stickers, etc.
- Able to identify, support, link, and enhance the role and value of all key players including the target audiences/recipients, influencers, social support networks, health facilities, community leaders and policy makers
- Represented by a simple image, tagline/signature line, and/or other visual or mnemonic device that allows for instant identification and recognition that can link materials, messages, partners, and programs.

Link the branding strategy with health providers, community networks, media channels, and market based solutions. Allow, support, and facilitate their adoption and use of the branding strategy in their own programs and interventions.

Explore opportunities for branding “healthy families”. A “healthy family” focus:

- Places health ownership in the hands of families and their communities through self-determination, local governance & service/information providers
- Fosters convergence of HEO programs at the household level with focus on key indicators/outcomes
- Recognizes families who adopt and follow life-stage health practices

- Creates sustainable demand for health driven by family consumers.

Explore opportunities for branding “healthy communities”. A “healthy community” focus:

- Promotes and recognizes the growing numbers of “healthy households” in the community
- Provides families with easy access to basic quality health services and promotes opportunities and provides support to making health choices
- Promotes and recognizes public, NGO, commercial, social, educational, religious, and political community organizations that can work collectively to address community health needs and opportunities; creating normative change
- Establishes the role of local governance taking an active role in furthering the community health agenda and in monitoring and promoting key health indicators and improvements over time.

Develop and publish “positioning and branding standards and guidelines” that will facilitate wide adoption and use by all the sectors, while maintaining integrity and consistency of application.

Explore ownership issues with the GoG and longer range expansion plans that can incorporate other health priorities and additional geographic markets beyond the Western Highlands.

## Building From the Program Up

Developing the positioning and branding strategy will take time and likely involve several rounds of audience consultations as formative research, including exploratory studies/concept testing and process mapping and reviews with stakeholders and counterparts. During this time and while developing the implementation guide and program plans, planners will want to explore mechanisms for aligning current interventions and building the convergence strategy through their existing programs.

Recommendations include:

- Establish a SBCC technical working group with representatives from all of the key health intervention programs. Involve this group in the development of the implementation guide, taking advantage of their expertise and helping to ensure ownership as the strategy moves forward.
- Via the technical working group; identify and collect information, plans, and examples of all SBCC interventions, materials, messages, and activities currently in use, underway and or in operation in the coming year. Use this collection to identify linkages, overlaps, gaps, and immediate opportunities for alignment and convergence. Identify interim mechanisms for applying the positioning/branding strategy to the existing materials where possible. Where this isn’t possible, develop longer range plans and timelines for eventual alignment.
- While most of the details moving forward will come from the next step of developing the implementation guides, planners will want to begin exploring the needs and opportunities for developing new SBCC interventions, including programs, campaigns, and materials that can operate at all levels (media, community, interpersonal) and that capture the integrated health interventions as fully positioned around the life-stages. As the new government comes on board and the stakeholders and partnerships build in the Western

Highlands, future plans for developing and launching a few critically timed overarching campaigns and/or events will provide an added “pull” to the program-up “push”, and create additional momentum to help drive implementation.

## Positioning and Branding: Two Illustrative Examples

### The “Best Family” Strategy

An aspirational focus on “doing your best and making the best decisions” to improve family life

Wanting the **best** for your kids... and yourself.

Learning about the **best** choices and options and making the **best** choice

Instituting **best** practices within health services

Motivate and recognize providers who do their **best** in counseling and treating clients

Easy identification of **best** practices in spacing, breastfeeding, complementary foods, safe delivery, etc.

Identifies, defines, and reinforces roles: moms who breastfeed provide the **best** food; couples that space to make the **best** life for their kids; the **best** moms and dads talk together about what is **best** for their children; the **best** providers are those that treat their clients **best**

Lends itself to market based approaches with fortified staples being the **best** staples, nutritious foods as **best** foods, diverse diets as **best** diets

Recognizes and reinforces efforts: trying and doing our **best** despite context, constraints, and cultural norms

Given the choice and proper information families will do the **best** they can

### The “Protected Family” Strategy

A focus on “protecting” the family from poor decisions and poor health

Wanting to **protect** your kids...and yourself.

Learning about the right choices and options that provide **protection**

Providing and teaching **protective** practices within health services

Motivate and recognize providers who **protect** their clients health through counseling and proper treatment

Easy identification of **protective** practices in spacing, breastfeeding, complementary feeding, safe delivery, etc.

Identifies, defines, and reinforces roles: dads who **protect** their families including their health; moms who breastfeed **protect** their babies; couples that space **protect** their kids future; **protective** parents talk together about how to **protect** their kids future; the best providers are those that **protect** their clients health

Lends itself to market based approaches with diverse diets, fortified staples, and more nutritious foods **protecting** against nutrient deficiencies

Providing the best **protection** to our families no matter what the circumstances

## 7. RESEARCH GAPS

### Research/Information Gaps

A key first step in developing any SBCC strategy includes gathering background data and documents, conducting secondary literature reviews, and interviewing stakeholders, partners, and key participants as part of the initial learning process. The breadth and depth of the data gathering and analysis is often driven by the availability and accessibility of information, and time and resources available. One great benefit of this exercise is not just learning what you can know, but identifying what you don't know. In reviewing the background information used to inform the development of this overarching communication strategy, planners identified the following information gaps. It is worth noting that this information may in fact exist, but wasn't found in the time period when this strategy was being prepared. Regardless, as the process moves forward to the development of the implementation guide, the planning team will want to consider the information gaps below.

Specifically, the planning team will want to determine:

1. if the gaps are valid;
2. the value/use of the missing information weighed against the costs of research and gathering it;
3. the best mechanisms/research protocols for collecting the high value information;
4. opportunities for convergence and economies of scale in information gathering;
5. how best to build this research into the implementation plans of the programs (mechanics of who will be doing what, when); and
6. how best to maximize the value and use of the information across the SBCC interventions.

### FP, MCH, Nutrition Gaps:

- Formative research is needed to provide further insights/knowledge about the information, motivation, capacity to act, influences, and normative behavior among the selected life-stage audiences relative to the key health interventions.
- What is the role of the mother-in-law relative to the life-stage of young couples; how does she and others understand her role in influencing family decisions on FP, MCH, and nutrition: what are her barriers; what influences her and what may change her attitudes and improve her influence relative to supporting family planning, optimal spacing, skilled attendants at birth, planning for obstetric emergencies, optimal breastfeeding and family nutrition; etc. Has USAID or other groups identified any successful windows of opportunity, that integrate mother-in-laws as a resource and effective partner?
- What are the culturally appropriate and language specific channels and activities that have been successful or seem promising in creating change in the Western Highlands? What can we learn from these case studies?
- What are successes with male involvement in the Western Highlands; what are the barriers and opportunities for fathers to participate in key life-stage interventions including family planning, emergency planning, and optimal nutrition during the first 1,000 days; what influences them and what are the strategies to increase and enhance their direct involvement?
- How can we better understand and counter the traditions and myths that negatively impact on health decisions; what are the best ways to change cultural beliefs regarding “hot and cold foods” for infants, colostrum, the need for the “health care provider exam” within 48 hours after birth; and other deep cultural and traditional practices underlying birthing, family planning, and nutritional practices?
- How can we better understand the causes for child mortality in the post neonatal period and develop appropriate prevention interventions? How can we better understand the hygiene issues that impact nutrition during the first 1,000 days; what are the most effective interventions; how do they best engage with those most involved including the pregnant moms, fathers, mother-in-laws, and older siblings?
- How do we maximize the ability and capacity of the health delivery system to integrate and offer the full range of information, counseling and services specific to the needs of young couples and adolescents; which modern methods are consistently available and which are subject to stock-outs; how can the hierarchy of services better meet the needs of local obstetric emergency plans and events; what are the barriers to incorporating FP, MCH, & nutrition at all key consumer touch-points within the health delivery system; what is available and/or could be available for youth friendly services to adolescents; how can we address stigma, reduce cultural discrimination, mitigate bias, and move services and outreach towards a client centered approach based on caring and respect?
- What are the most promising community based interventions and what traditional and non-traditional organizations should we involve; what has been and what can be the role of religious organizations and churches in supporting better nutrition, healthier pregnancies and deliveries, optimal spacing and family planning and how can they best be engaged to influence their members, communities, and other community organizations?
- What are the barriers and opportunities among national politicians and ministry leaders to engaging the agriculture and food value chains in addressing malnutrition and stunting; what are the barriers and opportunities at the local level for leveraging market based approaches to improving the quantity and quality of affordable, optimally nutritious food choices, including complementary foods and food supplements for pregnant moms and their children

(6-24 months of age) during the first 1,000 days and more nutritious foods for older children and adolescents?

### HIV Gaps:

- Updated environmental scans and mapping are needed to get the most current information on local human rights associations (which groups, what roles and what geographic coverage); HIV/STI services (who is offering what, where, and with what coverage) and of the critical target populations including men who have sex with men (MSM), transgender and female sex workers (FSW) hot spots in departmental urban areas.
- What are the barriers, opportunities, and existing resources linking family planning, STI, and HIV services in the Western Highlands?

### Education Gaps:

- What are the successful models of school based health and nutrition programming in the Western Highlands; what are the formal curriculum and informal learning opportunities; how do these link with health and nutrition in the household and specifically with the first thousand days; how do these link with adolescents, and with the larger community; can and how can this be a platform for improving the value of schools, expanding learning and reading into the larger community, and better connect schools with families, community organizations and local leaders?

## 8. MONITORING AND EVALUATION

In addition to the formative research that will guide the development of interventions under the overarching communication strategy, monitoring and evaluation of these interventions will be critical to developing the learning necessary to make midcourse corrections and to expand and scale up successes across the region.

As part of the development of the implementation guide, planners will want to develop a consolidated set of indicators that can measure progress towards the key health outcomes based on the convergence strategy and life-stage approach. In addition, planners will develop a set of monitoring checklists and tracking/measurement tools designed to capture process measures, outputs and impacts, and to provide background context and understanding to any future outcome evaluations. (These can include measures of institutional change, community participation, interpersonal communication and counseling, health seeking behaviors, and so on.) Finally, planners will want to develop a “learning plan” model and a knowledge management/sharing platform which can serve as a shared platform for all the stakeholders and partners to facilitate and share learning across the health issues, life-stages, and Western Highlands region. There is much that is new under this SBCC convergence strategy. While it is based on sound theory and evidenced based practices, the unique challenges of the region offer opportunities for innovation, calculated risk taking and market testing of new ideas, and developing new models of interventions; all of which can lead to significant learning and advancing the field. The program teams will want to maximize this learning and publish and share results, contribute to building new evidence, and generate and disseminate valuable insights and information to other countries seeking to develop a more robust program of health integration.



Specific process measures and outcome indicators will be identified and codified in the implementation guide. In addition, the game plan for creating the operational framework for the learning model and knowledge management platform will be outlined and included in the guide.

## 9. NEXT STEPS:

This overarching SBCC convergence strategy is intended to be an initial draft of a new approach to SBCC and health promotion in Guatemala. It intentionally attempts to shift several paradigms, including:

- Shifting from a focus on health issues to a focus on meeting the health needs at key life-stages;
- Moving from the health delivery system as the driver of health to the households and communities as drivers of health;
- Shifting the balance of “treatment only” to a balance of “prevention and treatment” in health seeking behaviors;
- Closing the gaps between agriculture and nutrition, food and nutrition, and healthy nutrition (eating right) versus sick nutrition (treatment resulting from not eating right);
- Linking schools, education, adolescents and health
- Changing and creating norms, gender constructs, and enabling environments that make good health a part of everyday living and everybody’s business in the community

This is a tall order; and if this first draft of the convergence strategy ends up on a bookshelf, it is destined to be a failure. Rather, the authors intend and hope that this document becomes a starting point for debate, discussion and further planning. With this in mind, the following next steps are recommended for consideration:

### Reviewing the Draft

A critical first step will be the collective review and discussion of this draft strategy. HEO/USAID will want to carefully review the content and implications of the strategy, identify and internalize some of the change strategies, and continue to refine and revise components as needed or warranted. It will and should be a living document that is updated and refined over time; especially as new information becomes available, stakeholders and partners become involved and take over ownership, and lessons are learned during all stages of implementation.

### Developing the Implementation Guide & Next Level of Plans

The strategy outlines the challenges, opportunities, and directions for creating an overarching SBCC program in Guatemala. It does not yet include the more detailed and tactical roadmap for getting there. The next step in the process will be to develop the implementation guide that will provide this more granular roadmap.

### Filling Gaps

Research/information gaps identified during the development of this strategy should be reviewed and evaluated. If missing information exists, it should be collected and used to further inform the development of the implementation guide. Other gaps will need to be considered and plans to fill the gaps will need to be addressed.

### **Creating a Preliminary Game Plan for Developing the Implementation Guide**

Developing the implementation guide will require a highly collaborative process to ensure that plans are realistic, affordable, actionable, and acceptable to all concerned stakeholders and parties. To get this process started, the following steps are suggested for consideration.

#### **Conduct an external review and assessment.**

Outline a process and specific steps that identifies the key components supported by other donors and the GoG, and that facilitates a systematic collection and program review of their current and planned health/education communication programs, materials, messages, products, and plans; and the associated research / background documents behind their interventions.

Based on the formative work above, develop a set of parameters around which the HEO supported interventions will focus and complement/align with other donor and GoG interventions.

#### **Conduct an internal review and assessment.**

Outline a process and specific steps that identifies key components for convergence/integration within the HEO supported interventions and that facilitates a systematic program review and collection of all previous/existing, current, and planned communication materials, messages, products, programs, plans, and associated research / background documents for each of the intervention areas in health and education. Use this collection as the base analysis of the current SBCC programs and to provide the needed inputs for planning and consensus building workshops that will drive the implementation guide.

#### **Engage active participation in implementation planning.**

Engage the active participation of HEO leaders in key planning workshops associated with the development of the SBCC Strategy Implementation Guide. Specific workshops (to be determined in the planning of the implementation guide) might include:

- Workshop on converging and integrating existing component systems including: across GoG ministries; within and across health service delivery systems; within and across key community-based organizations; within the households; and within and across various media, advocacy, interpersonal, and community based channels. Outcomes of this workshop can include: specific consensus-built plans for convergence/alignment across existing structures; an integrated management plan for consolidating/leveraging future research, design, production, procurement, and management of interventions by life stages; and the identification, assignment, and management of a core SBCC working group with committed representatives from all of the relevant health/education interventions and a regular meeting schedule.
- Workshop (with HEO officers and SBCC working group members) on message and materials development including identification and consensus on message priority, technical content, hierarchy (of objectives and audiences) and gateway (starting points/consolidation points) priorities, and how best to align/update/use current materials. In addition, this workshop can explore ideas/themes behind a branding strategy that might provide direction/insights into how best to capture, converge, and consolidate SBCC interventions/materials/ messages around the life stage segments. Outcomes of this workshop can include: consensus-built guidelines on technical content and “style” of message packaging/presentation; specific plans for aligning, changing,

using, and/or sharing in the development of new interventions, materials, and messages around the life-stage segments. In addition, this workshop can develop metrics and monitoring systems to support, track, and help manage the convergence process as it moves forward.

### **Develop guidelines and tools.**

Based on the workshops, develop specific guidelines and tools to facilitate alignment of SBCC interventions and program materials (these guidelines will be incorporated into the larger SBCC Implementation Guide). Begin using guidelines in program/materials development and implementation, and monitor progress to determine where things are working, not working, and how best to improve utility and outputs/outcomes.

### **Select a market to get started.**

Select a representative “market” within the Western Highlands as a starting point for developing/implementing life-stage SBCC interventions. Include convergence of community and health service interventions aligned with SBCC strategies. Involve significant participation of community, health, and family representatives to provide inputs and learning. Develop feedback loops at key stages in the development and implementation, monitor and make mid-course corrections, capture learnings, and measure interim impact. Assess strengths, weaknesses, and lessons learned for consideration in either changing the approach or rolling out a refined version of the approach across the larger region.

### **Develop and refine monitoring checklists.**

To monitor progress within HEO, the team will develop simple monitoring checklists and tools to track and measure the use, utility, and outputs associated with workshop outcomes and adoption of implementation guidelines. These can include both process and output measures.

Illustrative examples include:

#### ***Process Measures***

- Formation of the SBCC technical working group (TWG)
- Attendance/participation at SBCC-TWG workshops and meetings
- Numbers and types of formative research activities that incorporate 2 or more life stage health areas into design
- Numbers and types of interventions designed to facilitate the convergence of health service delivery around life-stage interventions. (Examples might include: training, policy/procedure manuals, management structures, rewards/incentives, etc.)
- Numbers and types of interventions designed to facilitate the convergence of community organizations around life-stage interventions. (Examples might include: orientation workshops, community meetings, advocacy, technical assistance, etc.)

#### ***Output Measures***

- Numbers, types, and uses of SBCC materials/messages revised to reflect technical guidelines
- Numbers, types, and uses of SBCC materials that integrate 2 or more health/education areas built around life-stage needs
- Numbers, types, and examples of health centers/facilities that integrate 2 or more life-stage health areas into routine clinical/outreach practice

- Numbers and types of clients served/receiving integrated services built around life-stages through the health system(s)
- Numbers, types, and uses of media campaigns, advocacy activities, and community based interventions that focus on life-stage and incorporate 2 or more appropriate health/education areas

### Factor lessons learned into the implementation guide and program plans

Use the experiences gained through the planning and implementation process as feedback loops to refine the implementation guide and detailed plans and to continually strengthen the design and impact of on-going interventions.

## 10. TIMELINE

The timeline for the development, rollout and implementation of the SBCC strategies is outlined in the following graph. Key tasks to complete between October 2011 and June 2012 are to:

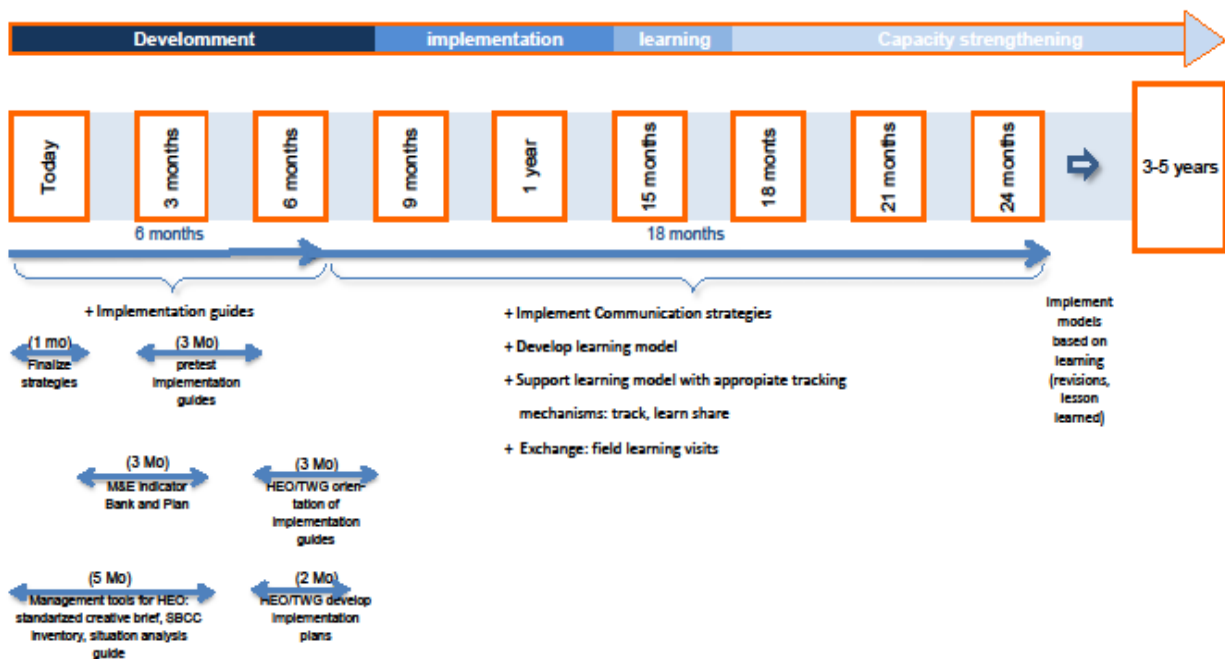
- Finalize the Overarching and Individual HEO Communication Strategies and M&E plan,
- Select the technical working group members,
- Create the Implementation Guide,
- Implementers develop their implementation plans,
- Rollout the plans in a phased way with the new government.

After June 2012, the next 18 months will be in part, a learning laboratory, building in opportunities for monitoring, adopting and testing different approaches across the implementing partners.

- Plans are being implemented,
- The efforts are tracked and shared
- Exchanges between sites and SBCC implementing teams are happening.

At the end of the 18 months, the SBCC implementation models are revised and adjusted based on the learning and years 3-5 continue with activities grounded in evidence-based successes.

## Timeline: SBCC Strategies



## 11. THEORIES OF CHANGE

This overarching communication strategy and the related health strategies in the appendix build off of a range of evidence-based best practices in health and prevention, and incorporate several key theories and models of change in the approach and recommendations. Ultimately, the overarching communication strategy seeks to create the change of significantly improving the health status and critical health outcomes of Guatemalan families living in the Western Highlands. To create this change, the strategy uses an ecological model that focuses on creating organizational changes in the key institutions that fund, govern and deliver health services; which in turn can help support and lead social and behavioral change in the households and communities where families live. Several of the change theories and models are outlined below:

## Social and Behavior Change: Western Highland Families and Communities

Social and behavior change strategies rely on social learning theory, social cognitive theory under the health belief model, stages of change, diffusion of innovation, theory of social norms, and positive deviance.

Theory of **social learning** suggests that people learn by observing the actions of others; seeing the consequences of those actions (good or bad); internalizing such actions in their own lives; and trying out those actions based on the perceived benefits of the consequences. Inherent in this theory is the modeling of behaviors, an understanding of self-efficacy (the ability and confidence to take action), and a recognition of the role of social norms.

The **health belief model** assumes that beliefs about certain health issues can help predict health behaviors. It looks at: perceived risk of susceptibility about getting/having a health problem (Am I at risk of getting this problem); perceived risk of vulnerability to the health problem (If I have the health problem, how bad can/will it be); perceptions about the efficacy of taking (preventive) action (If I take action, will it matter and make a difference); and perceived self efficacy in taking actions (Do I think I can effectively take this action?)

**Stages of change** theory helps understand an individual's readiness to change: across a 5-stage process of: 1. pre-contemplation, 2. contemplation, 3. preparation, 4. action, and 5. maintenance. Formative research can help identify the stage of readiness, which in turn can be used to shape the information and messages needed at that particular stage.

**Diffusion of innovation** describes how new ideas and practices can spread through social networks and the larger society over time. It recognizes the role of early adopters, and the nature of the innovation and characteristics of the social networks, taking into account the momentum of the spread of ideas through late adopters and factors in the realities of the never adopters.

**Social norm** theory suggests that societies have explicit and implicit "rules" that discriminate between appropriate (socially acceptable) and inappropriate (socially unacceptable) values, beliefs, attitudes, and behaviors. These collective norms work at the society level, representing a collective code of conduct (or expectation of conduct.) Perceived norms are the result of individual interpretation of the larger collective norms. These can be divided into injunctive norms (what should be done) and descriptive norms (what is actually being done). Stigmatization is the result when societies/groups establish "negative norms", which defines a lack of approval from the collective norms. Inherent in this theory is the recognition that social norms play a defining role and that individuals tend to want to belong to and fit in with what's acceptable, or at least maintain the appearance of doing so. Social norms can and do change over time. Perceptions about social norms are a powerful influencer which can provide permission for, reinforcement of, and impetus to changing behaviors.

The **positive deviants** approach seeks to understand why individuals and/or institutions practice the desired healthy/organizational behaviors, despite the fact that the majority of other individuals and institutions around them do not. These positive deviations from the norms can provide keen insights into why they do what they do (despite the environmental constraints and current norms) and why those around them don't. In addition, positive deviants can provide insights into better understanding the motivations behind early adopters that can lead into more effective diffusion strategies.

## Organizational Change: USAID & Partners, GoG, MOH Service Delivery

The strategy relies on theories of organizational change including those that focus on policies, program structures, organizational development, and incorporating adult learning, media theories, and positive deviance (in the MOH Service Delivery system)

Theories of **organizational change** provide understanding and insights in to how best to create change in the key organizations in Guatemala, necessary to supporting the desired health impacts. They include understandings of models of organizational development and the role of internal and external “pressures”, policies, incentives, structures, and leadership in creating and managing change. They recognize that the interests of organizations in stability, predictability and hierarchy are balanced by changes in the landscape and broader environment that create opportunities and/or threats and the stimulus for renewal, survival and evolving change. Many of the social and behavior change theories outlined in the section above play a similar role in facilitating organizational change within organizations. This includes: cognitive **adult learning**, which incorporates experience, critical reflection, and development; models of **positive deviance** that provide insights and opportunities for diffusion; and **media theories** (explained below.)

**Media theories** suggest that when properly employed, media can set an agenda (put an issue in front of key audiences that wasn’t as salient as before); frame issues (help define ideas and consequences in simple, memorable ways); persuade (providing information along with a particular point of view that changes audience perceptions about an issue); role model (by using social learning to show behaviors and consequences) and create a sense of social norms (seeing and hearing it in the media means people are thinking, talking and acting around the issue).

## References

The following resources provide a more in-depth review of the theories of change and and change models underpinning the overarching communication strategy:

Appelbaum, R.P. (1970). *Theories of Social Change*. Chicago: Markham.

Bandura, A. (1977). *Social Learning Theory*. New York: General Learning Press.

Berkowitz, Alan D. (2004). *The Social Norms Approach: Theory, Research, and Annotated Bibliography*. Unpublished Report.

Glanz, K. Barbara K. Rimer, and K. Viswanath. (2008). *Health Behavior and Health Education: Theory, Research, and Practice* (Fourth Edition). San Francisco: Jossey-Bass, Inc.

Kubisch, Anne et al. (2002). *Voices from the Field II: Reflections on Comprehensive Community Change*. New York: The Aspen Institute Roundtable on Community Change.

Lapinski, M.K., and Rajiv Rimal. (2005). An Explication of Social Norms. *Communication Theory* 15.2: 127-147.

Rimal, Rajiv, and Kevin Newl. (2005). How Behaviors are Influenced by Perceived Norms. *Communication Research* 32.3: 389-414.

Rogers, E. (2003). *Diffusion of Innovations* (Fifth Edition). New York: Free Press.

Zeitlin, M.F. et al. (1990). *Positive Deviance in Child Nutrition*. Tokyo, Japan: The United Nations University Publications.

In addition, more information about social cognitive and adult learning theory, diffusion, and stages of change can be found at the following links:

Social cognitive theory:

[http://www.utwente.nl/cw/theorieenoverzicht/Theory%20clusters/Health%20Communication/Social\\_cognitive\\_theory.doc/](http://www.utwente.nl/cw/theorieenoverzicht/Theory%20clusters/Health%20Communication/Social_cognitive_theory.doc/)

Adult learning theory: <http://www2.honolulu.hawaii.edu/facdev/guidebk/teachtip/adults-2.htm>)

Diffusion of innovation <http://www.jstor.org/pss/1965331> and  
[http://a.parsons.edu/~limam240/thesis/documents/Diffusion\\_of\\_Innovations.pdf](http://a.parsons.edu/~limam240/thesis/documents/Diffusion_of_Innovations.pdf)

Stages of change: <http://www.aafp.org/afp/20000301/1409.html>)



## APPENDIX 1

### Health SBCC Strategies

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**USAID** | **GUATEMALA**  
FROM THE AMERICAN PEOPLE



# Social Behavior Change Communication Strategy

USAID/Guatemala

Health and Education Office

# Family Planning

October 2011

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## 1. SUMMARY OF ANALYSIS

### *Problem Statement*

Unmet need for contraceptives and poor birth spacing among rural, indigenous women in Guatemala is contributing to unplanned pregnancies, increased health risks and poor maternal and child health. The role of men, mothers-in-laws, and the church in decision making negatively influence a woman's ability to take action in reproductive health decisions. Limited access, poor quality health service, health provider biases, and myths about side effects and poor client provider interaction further limit successful outcomes. Deep gender/cultural norms and a lack of accurate and culturally appropriate information about family planning prevent women and men from seeking appropriate modern family planning services.

### *Information/Research Gaps*

- Formative research providing further knowledge about the information, motivation, capacity to act and normative behavior among the selected audiences
- What is the role of the mother-in-law: what are her barriers and aspects that would help her promote family planning
- Has USAID or other groups identified windows of opportunity, to integrate mothers-in-law as a resource and partners?
- What are culturally appropriate and language specific channels and activities that have been successful or seem promising?
- What are successes with male involvement (in any type of program and specifically in family planning)?
- Which modern methods are consistently available?
- Are there religious organizations who have been potential partners in family planning to influence the social norms, potential partners?

### *Required Changes*

- Newly "married" couples discuss and share ideas and plans for having children, including when, how many, and how best to space between births. These discussions are shared with key family influentials, including mother in laws.

- Women are familiar with modern methods and believe FP is important, widely practiced, and socially acceptable. They understand and value birth spacing, seeking to optimally space between children as a way of providing the best nutrition and developmental support, and future. This belief is supported by their husbands, families, and the community at large.
- Women have assertive conversations with family health providers, husbands and mother-in-laws about their needs and options and select the method most appropriate for their needs. Myths and fears about side effects are addressed.
- Adolescent girls and boys understand basic reproductive health, and know how to avoid and protect themselves against unintended/unwanted pregnancy. They have access to appropriate information through youth friendly health centers, community organizations, and local NGOs.
- More couples use modern FP methods and are successful. They believe that belief that modern contraceptive is widely used and important
- HCP's become a trusted source of information. They provide accurate, culturally appropriate and relevant information to the couples and adolescents seeking information. Doctors and nurses openly talking about modern FP during office visits;
- Doctors increasing the value of why; nurses doing the counseling
- Community leaders understand and endorse family planning programs to improve quality of life and health of families; youth friendly services are more widely available.
- Increased number of couples that use family planning methods
- Culturally appropriate materials with guiding points – different audiences and add youth to the mix

## Theory of Changes

### *Tipping Points:*

- Better communication between husband and wife
- Better client oriented services
- Young new clients better informed

We expect spousal communication concepts to help move the tipping point for change on the demand side for family planning. Concepts that support our assumptions can be found in: **theory of social norms** that focus on changing perceived norms and stigma against family planning; **diffusion of innovations and social learning theory** addressing self-efficacy and using role modeling to support the expected change; and elements of the positive deviance approach to address not only barriers to change but existing assets; **media theories** that can set agendas, persuade, frame, model, and reinforce new gender constructs/roles.

We also expect client-oriented services to move the tipping point for change on the supply side. The concepts that these assumptions are based on are used in models of **patient centered communication** functions related to consumerism, physician patient relationship and health literacy. Concepts from the **diffusion of innovations**, theory of social learning, and social norms will support service re-orientation. The **theory of organizational change** including organizational policies, structure of programs/services, and institutionalization of practices is important as is are **media theories** to promote services, help with agenda setting, framing,

persuasion, modeling, reinforcement, and perceived norms;. All are based on elements of ecological models, specifically intrapersonal factors and interpersonal processes

## 2. COMMUNICATION STRATEGY

<b>Final audience segmentation</b>		
Users	Women (18-49) Youth (12-20)	<i>Directly affected</i> as they are ultimately end users of family planning.
	Men (20-49) Youth : 12-20	<i>Indirectly affected.</i> From the user's perspective, the most trusted supplier of family planning products and services, yet not frequently prioritizing promotion of family planning as s/he tends to perceive it as somebody else's role (usually nurse or social worker)
	Local NGOs	Major role in promoting, recommending and supplying family planning products in health centers, clinics and hospitals
	Civil Society	<i>Indirectly influencing.</i> From the user's perspective, the most trusted supplier of family planning products and services, yet not frequently prioritizing promotion of family planning as s/he tends to perceive it as somebody else's role (usually nurse or social worker)
Suppliers	Doctors	<i>Directly influencing.</i> From the user's perspective, the most trusted supplier of family planning products and services, yet not frequently prioritizing promotion of family planning as s/he tends to perceive it as somebody else's role (usually nurse or social worker)
	Auxiliary Nurses	<i>Directly influencing.</i> Major role in promoting, recommending and supplying family planning products in health centers, clinics and hospitals

Community agents	<i>Directly Influencing.</i> Active role as educator regarding importance and benefits of family planning, promoter and provider of family planning products and services at the community level, including referrals to specific providers through vouchers for services and/or transportation
Clinic Support Staff	<i>Directly influencing.</i> Highly trusted source of information – of any type, including family planning – in public health centers, clinics and hospitals

## Audiences

<i>Audience</i>	<i>Desired Changes</i>	<i>Barriers</i>	<i>Objectives</i>
Women	<ul style="list-style-type: none"> <li>• Increased use of family planning/empowerment</li> <li>• Increased birth spacing</li> <li>• Decreased unmet need</li> </ul>	<ul style="list-style-type: none"> <li>• Partner</li> <li>• Lack of respect from service providers</li> <li>• The mother-in-law</li> <li>• Social norms and stigma of family planning (something 'wrong' with woman seeking family planning)</li> <li>• Religion</li> <li>• Healthcare system not oriented to Mayan patients;</li> <li>• Women have myths and don't trust side effects of modern family planning methods and don't trust the healthcare system.</li> <li>• Women perceive themselves as <i>mothers</i> rather than as <i>women</i></li> <li>• Distant and unfriendly</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of women who can identify more than one modern contraceptive method</li> <li>• Increased number of women who are able to choose appropriate family planning method for themselves</li> <li>• Increased number of women who report they believe use of modern contraception is widespread in the community</li> <li>• Increased number of women who report talking to a health worker about family planning methods and asking about side effects</li> </ul>

		<p>services not integrated with other services</p> <ul style="list-style-type: none"> <li>• Schedules don't work for the clients</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of women who report positive provider-client interaction on family planning at health facilities</li> <li>• Increased number of women who report talking to their partner about family planning</li> </ul>
Men	<ul style="list-style-type: none"> <li>• Increased use of family planning</li> <li>• Increased shared responsibility on family planning</li> <li>• Increased respect for women's right to choose (family planning methods)</li> </ul>	<ul style="list-style-type: none"> <li>• Machismo</li> <li>• Religion</li> <li>• Social norms and stigma of family planning (man decides how many and when to have children; woman using family planning means she is cheating on him)</li> <li>• Limited knowledge of FP – although eager to learn</li> <li>• Healthcare system schedule and location of services don't work for men's schedules</li> <li>• Man's mother (demanding grandchildren from 'the man')</li> <li>• Family planning is a women's issue</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of men who report talking to their partner about family planning</li> <li>• Increased number of men who approve of the use of modern contraceptive methods for child spacing and for limiting the number of their children</li> <li>• Increased number of men who report talking to a health worker about family planning methods</li> </ul>



Local NGOs	<ul style="list-style-type: none"> <li>• More and better promotion of family planning</li> <li>• Improved quality of services</li> <li>• Balanced and culturally appropriate counseling techniques</li> <li>• Integration with provider networks and local Gov. (referrals)</li> </ul>	<ul style="list-style-type: none"> <li>• Weak technical capacity</li> <li>• Poor monitoring systems that limit feedback to improve interventions</li> <li>• Competing priorities</li> <li>• Conflict of interests with demands from churches</li> <li>• Suffer consequences derived from poor logistics around the supply chain</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of providers who practice positive interpersonal communication skills to counsel clients on family planning</li> <li>• Increased number of providers who report counseling patients on family planning methods</li> <li>• Increased number of providers who provide accurate information on the effectiveness and side effects of modern contraceptive methods</li> <li>• Increased number of providers who become a trusted source of family planning</li> <li>• Increased number of providers who believe that fellow providers are trusted sources of family planning</li> </ul>
Doctors	<ul style="list-style-type: none"> <li>• More and better promotion of family planning</li> <li>• Improved quality of services.</li> <li>• Integrate – offer integrated services to connect FP w visits in health areas</li> </ul>	<ul style="list-style-type: none"> <li>• Social norms (nurse is lower in the power hierarchy, plus the family planning promotion is the role of the nurse or the social worker)</li> <li>• Health system demands limit attention to the client to the minimum required</li> <li>• Academic background on family planning (extremely weak)</li> <li>• MDs aren't trained in</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of providers who practice positive interpersonal communication skills to counsel clients on family planning</li> <li>• Increased number of providers who report counseling patients on family planning methods</li> <li>• Increased number of providers who provide accurate information on the effectiveness and</li> </ul>

		FP.	<p>side effects of modern contraceptive methods</p> <ul style="list-style-type: none"> <li>• Increased number of providers who become a trusted source of family planning</li> <li>• Increased number of providers who believe that fellow providers are trusted sources of family planning</li> </ul>
Nurses	<ul style="list-style-type: none"> <li>• Improve technical capabilities</li> <li>• Consistent use of tools in their counseling.</li> </ul>	<ul style="list-style-type: none"> <li>• Social norms (lack of respect to client's right to choose family planning method)</li> <li>• Work overload blocks active listening</li> <li>• Not client-oriented</li> <li>• No systematic approach or consistent use of teaching tools</li> <li>• Perception of own role, as a position of 'power' – linked to low work-related esteem</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of providers who practice positive interpersonal communication skills to counsel clients on family planning</li> <li>• Increased number of providers who report counseling patients on family planning methods</li> <li>• Increased number of providers who provide accurate information on the effectiveness and side effects of modern contraceptive methods</li> <li>• Increased number of providers who become a trusted source of family planning</li> <li>• Increased number of providers who believe that fellow providers are trusted sources of family planning</li> </ul>
Community Agents	<ul style="list-style-type: none"> <li>• Improved technical capabilities (family planning, and communication skills,</li> </ul>	<ul style="list-style-type: none"> <li>• No communication with clinics' staff</li> <li>• Methodologically rigid/ quality of</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of providers who practice positive interpersonal</li> </ul>

	<p>more specifically tailoring messages and listening to the client)</p> <ul style="list-style-type: none"> <li>• Increased capacity to make referrals and to use a voucher system.</li> <li>• More proactive and confident role in making referrals.</li> </ul>	<p>training received - – don't adapt their counseling to the clients need</p> <ul style="list-style-type: none"> <li>• Education level</li> <li>• Competitiveness within community reduces referrals to people in the same community and blocks adequate community service supply</li> <li>• Supply chain</li> <li>• Information systems</li> <li>• Referral capacities are weak.</li> <li>• Lack of voucher system.</li> </ul>	<p>communication skills to counsel clients on family planning</p> <ul style="list-style-type: none"> <li>• Increased number of providers who report counseling patients on family planning methods</li> <li>• Increased number of providers who provide accurate information on the effectiveness and side effects of modern contraceptive methods</li> <li>• Increased number of providers who become a trusted source of family planning</li> <li>• Increased number of providers who believe that fellow providers are trusted sources of family planning</li> </ul>
Clinic Support Staff	<ul style="list-style-type: none"> <li>• Improved positive attitude towards family planning and towards the clients</li> <li>• Improved teamwork</li> <li>• Able to accurately dispel myths and rumors about family planning</li> </ul>	<ul style="list-style-type: none"> <li>• Social norms-role does not include training in family planning</li> <li>• Lack of concept of client</li> <li>• Lack of concept of service provider</li> </ul>	<ul style="list-style-type: none"> <li>• Increase number support staff who practice positive communications skills when discussing family planning with client</li> </ul>

### Strategic Approach

For those who demand family planning products and services	Deliver interventions to influence social norms that stigmatize use of family planning
For those who supply family planning products and services	Developing client-oriented product and service delivery

## Positioning

Improved client-oriented services will allow men and women to plan together for happier and healthier families with more resources.

<b>Key Information</b>	
Women (18-49) Youth (12-20)	<ul style="list-style-type: none"> <li>• Birth spacing helps women be stronger and healthier for her family and herself</li> <li>• Having less children allows for having healthier children and better quality of life</li> <li>• Modern family planning methods are safe, reliable and accessible to you.</li> </ul>
Men (20-49) Youth : 12-20	<ul style="list-style-type: none"> <li>• It is the man's duty to plan together with their partner the number of children they want and the method with which they are going to space or avoid pregnancies</li> <li>• Birth spacing and fewer children allow more resources for the family and each child</li> </ul>
Local NGOs	<ul style="list-style-type: none"> <li>• Creating client-friendly services increases the number of users which will result in a stronger, healthier community with more resources</li> </ul>
Civil Society	<ul style="list-style-type: none"> <li>• Community leaders have the right to demand client-oriented services that respond to the family planning needs of the women in the community.</li> <li>• Communities that invest in family planning have better chances of economic growth</li> </ul>
Doctors	<ul style="list-style-type: none"> <li>• Prioritizing family planning helps improve the overall health of the community and your clients</li> <li>• Client-oriented services are crucial for successful family planning counseling</li> <li>• Teamwork results in less effort for individual</li> </ul>
Auxiliary Nurses	<ul style="list-style-type: none"> <li>• The user has the right to choose the family planning method she prefers</li> <li>• Different methods have different women</li> <li>• Client-oriented services are crucial for successful family planning counseling</li> <li>• Teamwork results in less effort for individual team members and has greater impact on the client</li> </ul>

Community agents	<ul style="list-style-type: none"> <li>• The user has the right to choose the family planning method she prefers</li> <li>• Counseling needs to be tailored according to the woman's needs</li> <li>• Different methods have different advantages for different women</li> <li>• Community-based services are easier to access for women and result in better family planning</li> </ul>
Clinic Support Staff	<p>The client has the right to be treated with respect The client has the right to receive correct information</p> <p>You are an important source of information for the client and you need to give them accurate information.</p>

### **Channels, Activities and Materials**

Women (18-49) Youth (12-20)	<p>Radio soap opera (<i>Novela</i>) Community radio talk shows</p> <p>Interpersonal activities (one-on-one and small group outreach)</p> <p>Information tables in markets and special events (ferias, community events, etc.)</p> <p>School based lifeskills programming for youth</p> <p>Youth groups</p>
Men (20-49) Youth : 12-20	<p>Radio spots</p> <p>Community radio talk shows combined with other topics, such as agriculture, soccer or business</p> <p>Billboards (i.e. dad holding the baby walking side- by-side with woman)</p> <p>Interpersonal activities (one-on-one and small group outreach), including counseling at the clinic</p> <p>Home visits that include discussions with the couple</p> <p>Information tables in soccer games and special events (ferias, community events, events at clinics, etc.)</p> <p>Contests, such as „feeding the baby with a bottle’, or “changing the baby’s diapers’ during ferias and special events</p> <p>Youth groups</p>
Local NGOs	<p>Training: client-oriented services</p> <p>Quality of service guides</p>
Civil Society	<p>Training: empowerment</p> <p>Community dialogues</p> <p>Advocacy through media, forums</p>
Doctors	<p>Client-oriented seminars</p>

	<p>Team-building activities  Training &amp; role playing – active listening, tailoring of products and services</p>
Auxiliary Nurses	<p>Client-oriented seminars  Team-building activities  Training &amp; role playing – active listening, tailoring of products and services</p>
Community agents	<ul style="list-style-type: none"> <li>• Training &amp; role playing – active listening, tailoring messages, recommendations and referrals</li> <li>• Meetings and discussions with community providers to search for common interests and mutual benefits when working together</li> </ul>
Clinic Support Staff	<ul style="list-style-type: none"> <li>• Training – family planning methods, active listening</li> <li>• Contests <i>„el empleado más amable del mes’</i></li> </ul>



**USAID** | **GUATEMALA**  
FROM THE AMERICAN PEOPLE



## Social Behavior Change Communication Strategy

**USAID**/Guatemala

**Health and Education Office**

## Maternal-Child Health

**October 2011**

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### 3. SUMMARY OF ANALYSIS

#### *Problem Statement*

Indigenous women in the rural highlands of Guatemala are giving birth at home without skilled attendants and no capacity to deal with an obstetric emergency. Complications from pregnancy and delivery result in a disproportional number of maternal deaths usually during delivery or the first week after giving birth. Babies are also highly vulnerable to morbidity and mortality. Chronic malnutrition of indigenous mothers, poor pre and postnatal care, limited transport options and limited access to and capacity of obstetric facilities that can handle emergencies create structural barriers to successful birth outcomes. Hypothermia, macro and micronutrient deficiencies contribute to poor outcomes. A lack of knowledge/ ability to identify danger and warning signs for both mother and child, traditional roles of husbands and mothers in laws in birthing and poor community readiness to respond to emergency situations further complicate successful health outcomes. Breastfeeding is valued, but traditionally not immediate nor exclusive for the first six months. Weaning and complimentary feeding practices, hygiene and lack of potable water contribute to risk. Families often don't recognize danger signs and symptoms for children resulting in poor management of upper respiratory infections and waterborne diseases.

Limited access to and poor quality of health services, fear of bad treatment and a lack of confidence in the health care system create barriers to successful client health provider interactions.

Deep gender/cultural norms and a lack of planning and birth preparedness within families and communities contribute to high maternal mortality rates. Chronic malnutrition of the mother and a health care system that doesn't respond to the clients in a contextually, culturally appropriate way further increase the vulnerability of the mother and child's health outcomes.

#### *Information/Research Gaps*

- Analyze causes for child mortality in post neonatal period and develop appropriate prevention interventions
- Barriers for the grandmothers to change desired behaviors
- Address myths and side effects.

- Cultural and traditional beliefs regarding hot and cold food for infants, colostrum, and the need for the health care provider examine the baby within 48 hours after birth

## *Required Changes*

**Mothers utilizing skilled attendants and facilities for routine prenatal care and postnatal care and support.** Mothers receive counseling on family planning and engage in good practices such as proper birth spacing, exclusive breastfeeding, giving colostrum to a baby within the first hour of birth, kangaroo mother, and receiving appropriate vaccinations on schedule with support from their husbands, mother-in-laws and community members.

- **Mothers understand and practice optimal breastfeeding and are supported by husbands, mothers in law and by the community.**
- **Mothers introduce timely and nutritionally appropriate foods at weaning and beyond** (appropriate mix of variety and volume of foods and supplements). **Family members and community leaders** able to recognize danger and warning signs in pregnancy, postnatal care and plan for emergency situations.
- **Health care providers** offer consistent and positive client oriented counseling and services for maternal child health needs using a client centered approach on the key topics such as prenatal care supplementation for mothers and children; growth monitoring, recognition of danger and warning signs; essential newborn care, management of IRA and ETA and early detection of signs of malnutrition.
- **Traditional birth attendants** trained in and practicing safe delivery methods, and include kangaroo mother care, treatment of parasites, appropriate follow-up care and identification of risk factors and signs of danger for mother and child.
- **Community designed SBCC programming**, updated on an annual basis, keeping the progress towards better MCH outcomes visible and relevant to the community.

## *Theories of Change*

Tipping points:

- **Family members and community leaders** able to recognize danger and warning signs in pregnancy, postnatal care and plan for emergency situations.
- **Health care providers** provide better services and counseling oriented to client needs
- **Advocacy** for births in the best possible conditions and monitoring the implementation of reproductive health law.
- **Empowered women** about their rights

We expect that the ability to recognize and plan a response to danger and warning signs in pregnancy and postnatal care will be a tipping point for reduced maternal mortality. The concept that these assumptions are based on come from both individual and community level theories. The **stages of change transtheoretical model** – which focuses on stages of individual motivation and readiness to change behaviors; the **theory of human motivation**, which analyzes the hierarchy of needs; the **Culture Centered Approach** for links between culture and structure, cultural relevance, and emotional motivators for community led commitment to change; as well as concepts from the **positive deviance approach** – community ownership of change process, community based and driven design and practice. **Additionally, models of diffusion of innovations, social learning theory, and social norms**; and includes elements of **ecological models** of intrapersonal factors and interpersonal processes

**A second tipping point is that health care providers offer consistent and positive client oriented counseling and services for maternal child health needs.** The assumption is that if the services are good quality, appropriate and appealing, they will be used. The concepts that these assumptions are based on are used in models of **patient centered communication** functions related to consumerism, physician patient relationship and health literacy. Concepts from the **diffusion of innovations**, theory of social learning, and social norms will support service re-orientation The **theory of organizational change** including organizational policies, structure of programs/services, and institutionalization of practices is important as is are **media theories** to promote services, help with agenda setting, framing, persuasion, modeling, reinforcement, and perceived norms;. All are based on elements of ecological models, specifically intrapersonal factors and interpersonal processes

## 4. COMMUNICATION STRATEGY

<b><i>Final Audience Segmentation</i></b>	
Pregnant Women and their Children within 1000 days	<i>Directly affected</i> as the health of the mother and child is most affected.
Men: father of children within 1000 days	<i>Directly influencing</i> as fathers are directly influencing the health of their family with their decisions
Grandmothers/mother in law	<i>Directly influencing</i> as they are directly affecting family decision making
Traditional Birth Attendant ( <i>comadronas</i> )	<i>Directly influencing.</i> Deliver the newborns and provide care to the mother and child as a direct adviser and influencer

Nurses (Most Likely Auxiliary Nurses)	<i>Directly influencing.</i> Central to supporting a mother from prenatal to postnatal; prenatal visits, growth and monitoring and nutritional counseling
Community agents	<i>Directly influencing.</i> Active roles as designers of the emergency obstetric care system; promotion of healthy nutrition practices and support for the prevention and management of IRA and ETA
PEC/Local NGOS	<i>Directly influencing.</i> Important role in supporting families and assess the capacity of health care workers to diagnose and manage illness
Doctors	<i>Directly influencing.</i> The most feared member of the health care team
Community leaders	<i>Directly influencing.</i> Mobilize community resources and advocate for appropriate water, hygiene, emergency transport support as well community based channels and markets for nutritionally optimal foods

## Audiences

<i>Audience</i>	<i>Desired Changes</i>	<i>Barriers</i>	<i>Objectives</i>
Pregnant Women and their Children within 1000 days	<ul style="list-style-type: none"> <li>Increased utilization of prenatal and postnatal care, and growth monitoring services.</li> <li>Increased utilization of skilled attendants during birth</li> <li>Exclusive breastfeeding in the first 6 months; first hour</li> </ul>	<ul style="list-style-type: none"> <li>Language barriers</li> <li>Cultural barriers</li> <li>Chronic malnutrition/anaemia</li> <li>Lack of access to information</li> </ul>	<ul style="list-style-type: none"> <li>Increase in the number of women who feel confident and who seek a minimum of 4 ANC visits</li> </ul>

	<ul style="list-style-type: none"> <li>• Ability to recognize danger and warning signs during pregnancy, delivery and in the young child</li> <li>• Post-partum family planning</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge of danger signs in pregnancy</li> <li>• Long distances to health facilities</li> <li>• Health provider attitudes</li> <li>• Traditional beliefs around births</li> <li>• Lack of male involvement</li> <li>• Lack of confidence about benefits of skilled attendants during delivery</li> <li>• Lack of knowledge regarding postpartum care and warning signs</li> <li>• Women don't visit clinics for the first two months- how do you reach the group during that time?</li> </ul>	<p>during pregnancy will improve their health and the health of their babies</p> <ul style="list-style-type: none"> <li>• Increase in the number of women who plan to deliver their babies at a health facility and have a transportation plan</li> <li>• Increase in the number who report positive provider client interaction in FP/RP/MCH</li> <li>• Increase in the number of women who know warning signs after delivery and when to seek the help of a health provider</li> <li>• Increase In the number of women who feel confident</li> </ul>
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			<p>that visiting a trained qualified provider within 48 hours after delivery will improve their health and the health of their babies</p> <ul style="list-style-type: none"> <li>• Increase in the number of women who speak to their partners about RH issues</li> </ul>
Men: father of children within 1000 days	<ul style="list-style-type: none"> <li>• Support his spouse to go for prenatal visits.</li> <li>• Increased utilization of skilled attendants during birth</li> <li>• Fathers seek prompt healthcare in emergency obstetric cases and have a plan to seek services</li> <li>• Ability to recognize danger and warning signs during pregnancy, delivery and in the young child</li> </ul>	<ul style="list-style-type: none"> <li>• Belief that reproductive health issues are a woman's responsibility</li> <li>• Traditional beliefs</li> <li>• Traditional lack of involvement with the child</li> <li>• Difficult to reach</li> <li>• Traditionally defer to their mothers opinion as the elder instead of planning with their wives how to prepare and make decisions during pregnancy.</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in the number of men who believe that prenatal visits and birth at a health facility will improve the health outcomes for their wives and children.</li> <li>• Increase in the number of men who have discussed a transportation plan for getting</li> </ul>

			<p>their spouses to a health facility before delivery</p> <ul style="list-style-type: none"><li>• Increase in the number of men who report positive provider client interaction in FP/RP/MC visits.</li><li>• Increase in the number of men who speak to their spouses about planning for pregnancy and childcare issues</li><li>• Increase in the number of men who accompany their partners to health facilities and delivery services</li><li>• Increase in the number of men who know warning signs after</li></ul>
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			delivery and for his young children and when to seek the help of a health provider
Grandmothers/mother in law	<ul style="list-style-type: none"> <li>• Uses her leading role to provide accurate advice to improve the mother and newborns health in the household</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge (inaccurate information)</li> <li>• Attitude towards innovation and “new” ideas</li> <li>• Lack of trust in western health care/traditional and cultural birthing and nutritional practices</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in the number of grandmothers who know warning signs during pregnancy, delivery and for the young child.</li> <li>• Increase in the number of grandmothers who support the seven essential nutrition practices.</li> </ul>
Traditional Birth Attendant ( <i>comadronas</i> )	<ul style="list-style-type: none"> <li>• Implementing safe deliveries which include prevention of hypothermia, active management of third stage of labor to prevent hemorrhage during childbirth and follow-up postnatal care within 24 hours and three days of birth to identify risk factors and signs of danger for both the mother and the baby</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Educational level</li> <li>• Cultural traditions</li> <li>• Language barriers</li> <li>• Selection by Mayan gods to be midwives</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in the number of <i>comadronas</i> who feel confident that implementing safe delivery practices will improve the birth experience</li> </ul>

	<p>ble to provide correct advice about optimal nutritional feeding practices for mother and child</p>		<p>for their patients</p> <ul style="list-style-type: none"> <li>• Increase in the number of TBA who report counseling family members on the risk factors and signs of danger for mother and baby</li> <li>• Increase in number of traditional birth attendants who accompany their clients to skilled facilities for prenatal, labor, postnatal or growth monitoring services.</li> </ul>
<p>Nurses (Most Likely Auxiliary Nurses)</p>	<ul style="list-style-type: none"> <li>• Positive provider-client encounters at all levels of service delivery</li> <li>• Nurses are providing accurate and relevant messages for their clients</li> <li>• Serve with apathy</li> </ul>	<ul style="list-style-type: none"> <li>• Too many patients not enough time</li> <li>• Biases toward the population served</li> <li>• Low pay</li> <li>• Lack of motivation</li> <li>• Language and cultural barriers</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in number of providers who practice positive interpersonal and intercultural skills to counsel patients</li> <li>• Increase</li> </ul>

		<ul style="list-style-type: none"> <li>• Lack of motivation and training in client oriented services</li> <li>• Knowledge and training in all aspects of integrated FP/RH/MCH</li> </ul>	<p>number in nurses that use IPC skills to deal with patients more effectively using less time</p> <ul style="list-style-type: none"> <li>• Increase in number of providers who report counseling patients on the importance of ANC visits and skilled attendants at childbirth</li> <li>• Increase in number of providers who believe that they are helping their patients to improve their quality of life</li> <li>• Increase in the number of providers who become a trusted source of FP/RP/MCH information and services</li> </ul>
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Community agents	<ul style="list-style-type: none"> <li>• Improved technical capabilities and communication skills for prevention and management of health concerns in MCH</li> <li>• Increased collaboration and assertive communication among health team members</li> </ul>	<ul style="list-style-type: none"> <li>• Methodologically rigid in presentations</li> <li>• Lack of accurate knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of providers who practice positive interpersonal and intercultural communication skills to support women and newborns and their families in MCH/FP/RH</li> <li>• Increased number of providers who provide accurate information on the danger and warning signs for pregnancy, post natal care for mother and child and case management of IRA and ETA</li> <li>• Increased number of community agents who can adapt their</li> </ul>
PEC/Local NGOS			

			counseling (charlas) to the specific needs of the audience.
Doctors	<ul style="list-style-type: none"> <li>• Provide key messages on FP/RH/MCH to their patients</li> <li>• Culturally relevant services</li> </ul>	<ul style="list-style-type: none"> <li>• Limited time</li> <li>• Language barriers</li> <li>• MI DIOS</li> <li>• System – weakest link.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased collaboration and assertive communication among health team members</li> <li>• Increased number of doctors who take advantage of key opportunities to communicate specific messages to families about MCH/FP/RH</li> </ul>
Community leaders	<ul style="list-style-type: none"> <li>• Community action plan for emergency obstetric and postnatal care including transportation</li> <li>• Community action plans regarding water and sanitation.</li> <li>• Community leaders demanding their rights.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of confidence about the FP/RH/MCH services for the community</li> <li>• Religious and traditional beliefs</li> <li>• Competing issues and resources</li> <li>• There is no monitoring of the processes</li> </ul>	<ul style="list-style-type: none"> <li>• Increase number of community leaders who understand the components of emergency obstetric care programs and support them in</li> </ul>

			<p>their communities</p> <ul style="list-style-type: none"> <li>• Increase the number of community leaders who become advocates for provision of better quality and more accessible MCH services and safe motherhood</li> <li>• Increase the number of community leaders who are sensitized</li> </ul>
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### *Strategic Approach*

Improve utilization of prenatal, puerperal and newborn care by improving health care providers skills to a client-oriented approach, encouraging families to attend at least 4 prenatal visits and actively seek post-natal care, and strengthening the community's ability to supportive community actions by developing integrated SBCC action plans.

## Positioning

**Families satisfied with health services will seek prenatal, puerperal and newborn care, improving mother's and newborn's health and well-being. We are families that support our women and children. My community takes care of me...**

<b>Key Information</b>	
<b>Pregnant Women and their Children within 1000 days</b>	<ul style="list-style-type: none"> <li>• Benefits of prenatal care</li> <li>• Risks of birth complications/ benefits of birth at health facility</li> <li>• Importance of mother and baby's nutrition</li> <li>• Hypothermia</li> <li>• Warning signs</li> <li>• Benefits of post-natal care</li> <li>• Components of essential newborn care</li> <li>• Assertive two-way communication/active listening techniques</li> <li>• 48 hour visits</li> <li>• IRA/diarrhea</li> </ul>
<b>Men: father of children within 1000 days</b>	<ul style="list-style-type: none"> <li>• Benefits of prenatal care</li> <li>• Risks of birth complications/ benefits of birth at health facility</li> <li>• Importance of mother's nutrition</li> <li>• Warning signs</li> <li>• Benefits of post-natal care</li> <li>• Components of essential newborn care</li> <li>• Assertive two-way communication/active listening techniques</li> </ul>
<b>Grandmothers/mother in law</b>	<ul style="list-style-type: none"> <li>• Importance of mother's nutrition before and after pregnancy</li> <li>• Hypothermia</li> <li>• Anemia</li> <li>• Warning signs</li> <li>• Benefits of post-natal care</li> <li>• Components of essential newborn care</li> </ul>
<b>Traditional Birth Attendant (comadronas)</b>	<ul style="list-style-type: none"> <li>• Hypothermia</li> <li>• Anemia</li> <li>• Warning signs</li> <li>• Benefits of post-natal care</li> <li>• Assertive two-way communication/active listening and teamwork strategies</li> </ul>

<b>Key Information</b>	
	<ul style="list-style-type: none"> <li>• Components of essential newborn care</li> <li>• Newborn infection management</li> <li>• Management of childhood diarrhea, pneumonia and malnutrition.</li> <li>• Growth monitoring and follow-up counseling for infants and young children</li> </ul>
<b>Nurses (Most Likely Auxiliary Nurses)</b>	<ul style="list-style-type: none"> <li>• Vaccination</li> <li>• Anemia</li> <li>• Warning signs</li> <li>• Kangaroo Mother Care Program</li> <li>• Vaccination</li> <li>• Benefits of post-natal care</li> <li>• Assertive two-way communication/active listening and teamwork strategies</li> <li>• Components of essential newborn care; of essential pre &amp; postnatal care of mom</li> <li>• Newborn infection management</li> <li>• Management of childhood diarrhea, pneumonia and malnutrition</li> <li>• Growth monitoring and follow-up counseling for infants and young children</li> </ul>
<b>Community agents</b>	<ul style="list-style-type: none"> <li>• Vaccination</li> <li>• Anemia</li> <li>• Warning signs</li> <li>• Kangaroo Mother Care Program</li> <li>• Vaccination</li> <li>• Benefits of post-natal care</li> <li>• Hypothermia</li> <li>• Assertive two-way communication/active listening and teamwork strategies</li> <li>• Components of essential newborn care</li> <li>• Newborn infection management</li> <li>• Management of childhood diarrhea, pneumonia and malnutrition</li> <li>• Growth monitoring and follow-up counseling for infants and young children</li> </ul>
<b>PEC/Local NGOS</b>	
<b>Doctors</b>	<ul style="list-style-type: none"> <li>• Vaccination</li> <li>• Anemia</li> <li>• Warning signs</li> <li>• Kangaroo Mother Care Program</li> <li>• Vaccination</li> <li>• Benefits of post-natal care</li> <li>• Hypothermia</li> <li>• Assertive two-way communication/active listening and teamwork strategies</li> </ul>



<b>Key Information</b>	
	<ul style="list-style-type: none"> <li>• Components of essential newborn care</li> <li>• Newborn infection management</li> <li>• Management of childhood diarrhea, pneumonia and malnutrition</li> <li>• Growth monitoring and follow-up counseling for infants and young children</li> </ul>
<b>Community leaders</b>	<ul style="list-style-type: none"> <li>• Benefits of prenatal care</li> <li>• Risks of birth complications/benefits of birth at health facility</li> <li>• Benefits of post-natal care</li> <li>• Assertive two-way communication/active listening and teamwork strategies</li> <li>• Components of essential newborn care</li> <li>• Management of childhood diarrhea, pneumonia and malnutrition</li> <li>• Planning your community response to obstetric emergencies</li> </ul>

<b>Channels, Activities and Materials</b>	
<b>Pregnant Women and their Children within 1000 days</b>	<ul style="list-style-type: none"> <li>• Interpersonal channels (Peer educators, home visits)</li> <li>• Radio: spots, soap operas, talk shows</li> <li>• Use of available technology creatively (IT - mobile telephone)</li> <li>• Information tables in markets, town festivals, street theatre</li> <li>• Church meetings</li> <li>• Visits to health posts/PEC</li> </ul>
<b>Men: father of children within 1000 days</b>	<ul style="list-style-type: none"> <li>• Radio spots – better during soccer</li> <li>• Community radio talk shows combined with other topics, such as agriculture</li> <li>• Billboards</li> <li>• Posters in the ‘cantina’</li> <li>• Interpersonal activities</li> <li>• Home visits that include discussions with the couple</li> <li>• Fairs</li> <li>• Meetings of men or areas of community dialogue (e.g. agricultural group meetings)</li> </ul>

<b>Channels, Activities and Materials</b>	
<b>Grandmothers/mother in law</b>	<ul style="list-style-type: none"> <li>• Interpersonal channels (Peer educators, home visits)</li> <li>• Radio: spots, soap operas, talk shows</li> <li>• Use of available technology creatively (IT - mobile telephone)</li> <li>• Information tables in markets, town festivals</li> <li>• Church meetings</li> </ul>
<b>Traditional Birth Attendant (comadronas)</b>	<ul style="list-style-type: none"> <li>• Peer education</li> <li>• Interpersonal channels</li> <li>• Home visits</li> <li>• Church visits</li> <li>• Clinics</li> </ul>
<b>Nurses (Most Likely Auxiliary Nurses)</b>	<ul style="list-style-type: none"> <li>• Client-oriented seminars</li> <li>• Team-building activities</li> <li>• Training &amp; role playing – active listening, tailoring of products and services, guides</li> </ul>
<b>Community agents</b>	<ul style="list-style-type: none"> <li>• Training &amp; role playing – active listening, tailoring messages, recommendations and referrals</li> <li>• Meetings and discussions with community providers to search for common interests and mutual benefits when working together</li> </ul>
<b>PEC/Local NGOS</b>	<ul style="list-style-type: none"> <li>•</li> </ul>
<b>Doctors</b>	<ul style="list-style-type: none"> <li>• Client-oriented seminars</li> <li>• Team-building activities</li> <li>• Training &amp; role playing – active listening, tailoring of products and services</li> <li>• Seminars</li> <li>• Kangaroo Mother Care Program</li> </ul>
<b>Community leaders</b>	<ul style="list-style-type: none"> <li>• Training: empowerment</li> <li>• Community dialogues</li> <li>• Advocacy through media, forums</li> </ul>



**USAID** | **GUATEMALA**  
FROM THE AMERICAN PEOPLE



# Social Behavior Change Communication

## Strategy

**USAID**/Guatemala

**Health and Education Office**

# Nutrition

**October 2011**

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## 5. SUMMARY OF ANALYSIS

### *Problem Statement*

The continuum of the first 1000 days, (from conception to alive and thriving two year old child and healthy mother) mark the difference in both mother and child's life. Rural, indigenous women and children under two have high chronic malnutrition rates due to structural and behavioral factors resulting in higher infant and maternal mortality and morbidity rates, low competitiveness, low productivity and stunting. Geographical location, community structure and leadership, family members and traditional practices influence the nutritional status of women and children. More specifically, grandmothers, husbands and midwives reinforce traditional customs and beliefs, which lead to poor nutrition outcomes. Parents purchase and decide the family foods and are often not aware of the link between food and nutrition.

Community based health services and health posts are not properly trained in nutrition counseling and delivery of health services are complicated by culturally inappropriate services. There is a general lack of coordination amongst local leaders, schools and churches to address nutrition issues. Agricultural and food value chains have yet to be fully engaged in enhancing the nutritional value of their crops and foods, in part because of a lack of consumer demand and financial and technical support to enter new markets.

Structural causes such as inequality and exclusion, normative gender roles and relationships, existing concepts and understanding around nutrition (prevention vs. treatment) in the health sector and the gaps between agriculture and nutrition and health and food, limit the progress towards better nourished families in the Western Highlands of Guatemala.

### *Information/Research Gaps*

- Role of the grandmother in feeding/nutrition practices of the household
- Barriers to the father's participation in family nutrition and care for the child in the first 1000 days of life.
- Community level activities: church's role as a participant in the response to nutrition programming in the villages
- What are the hygiene issues that impact nutrition (pregnant women, fathers, and siblings of children within 1000 days space within 1000 days of life)
- School based nutrition programming: review curriculum link and understand the links to the 1000 space

- Role of the churches: more specific understanding and
- Barriers to enhanced food value chains for nutrition among Ministry officials and national politicians
- Deep understanding of cultural and traditional practices underlying nutritional practices

### *Required Changes*

- Mothers understand and practice optimal breastfeeding and are supported by husbands, mothers in law and by the community (immediate initiation and exclusive breastfeeding for 6 months and continued breastfeeding with complimentary breastfeeding through two years of age). Mothers introduce timely and nutritionally appropriate foods at weaning and beyond (appropriate mix of variety and volume of foods).
- Parents and health providers expect taller children: malnutrition is visible
- Indigenous consumers actively demand and have greater access to affordable and nutritious food options. Readily available information motivates consumer choice for more nutritious foods.
- Health care providers offer consistent client oriented nutrition counseling for improved nutrition literacy and practices.
- National political leaders and Ministries are encouraged to invest more in nutrition and stimulate and support enhanced agricultural and food value chain markets for nutrition.
- Community and business leaders are motivated to promote nutrition through community channels and markets.

Seven nutrition actions:

- Optimal maternal nutrition during pregnancy and lactation – mom should rest and eat the right foods while she is pregnant and BFeeding
- optimal breastfeeding during the first 6 mos of life,
- optimal complimentary feeding from 6 mos of age with continued BF until 2 years of age and improved hygiene practices;
- appropriate nutritional care of sick and severely malnourished children;
- adequate vitamin A intake for women and children;
- adequate intake of iron and folic acid for women and children,
- adequate intake of iodine by all members of the household. (Feed the Future, April 2011, p 18, box)

## Theory of Changes

### *Tipping points:*

- Mothers get appropriate foods and time to rest during pregnancy.
- Mothers understand and practice optimal prenatal nutrition and breastfeeding and are supported by husbands, mothers-in-law and by the community.
- Indigenous consumers actively demand and have greater access to affordable and nutritious complimentary and weaning food options for mom and baby food options as complement.

We expect that mothers understanding and practice of optimal breastfeeding will help move the tipping point for change in chronic malnutrition. The concept that these assumptions are based on are used in the theory of organizational change including organizational policies, structure of programs/services, and institutionalization of practices; media theories including agenda setting, framing, persuasion, modeling, reinforcement, and perceived norms; diffusion of innovations, social learning theory, and social norms; and includes elements of ecological models of intrapersonal factors and interpersonal processes and models of patient centered communication functions related to consumerism, physician patient relationship and health literacy.

We also expect that active demand for affordable and nutritious food options will move the tipping point for change in chronic malnutrition

The concept that these assumptions are based on are used in the social learning, diffusion of innovations and social norms and media theories including agenda setting, framing, persuasion, modeling, reinforcement, and perceived norms to build and drive consumerism; social movement theories including advocacy, collective action, and policy/legislative change to drive leadership support to market based agriculture and food value chain interventions and community change; theories of organizational change and social marketing to stimulate supply and demand specific to creating enhanced markets for complementary foods.

## 6. COMMUNICATION STRATEGY

<b>Final audience segmentation</b>		
Users	Pregnant women and their children within 1000 days of life	<i>Directly Affected.</i> Main role in feeding the child. Continuum of care from the time that mom is pregnant through 2 years.
	Fathers of children within 1000 days of life	<i>Directly Influencing.</i> Need to involve men in feeding and care of children – role and decisions made by the father could impact breastfeeding practices and the choice and volume of food that the weaning child can eat.
	Siblings who cares for children within 1000 days of life	<i>Directly Influencing.</i> Their role in feeding babies as well as collaborating with household duties and errands while the mother takes care of the baby.
	Grandmothers	<i>Directly Influencing.</i> Influence they may have over the family on food choices and nutrition practices
Suppliers	Midwives	<i>Directly Influencing.</i> Their role influencing breastfeeding and supplemental food choices as well as collaborating with household duties/errands while mother takes care of the baby
	Nurses (including nurse assistants)	<i>Directly Influencing.</i> Influence they may have over the family on nutrition practices
	Community agents/PEC/NGO volunteers	<i>Directly Influencing.</i> Role as trusted source of information thanks to their wisdom and experience.
	Doctors	<i>Directly Influencing.</i> Ability to encourage optimal breastfeeding; growth monitoring and weighing; care of child when they are sick



	Community leaders/elected officials/ COCODES, etc.	<p>Directly influencing. Role in promoting breastfeeding, use of appropriate complementary feeding from 6 months of age with continued breastfeeding until 2 years of age, and appropriate hygiene practices.</p> <p>Their role to demand community hygiene and safe water supply; promote improved nutrition options and behaviors among their citizens.</p>
	Churches	<i>Directly Influencing.</i> Influence nutrition decisions and practices.
	Schools	<i>Directly Influencing.</i> Ability to organize community activities including education for appropriate nutrition; opportunity to organize community nutritional gardens.

<b>Audience</b>	<b>Desired Changes</b>	<b>Barriers</b>	<b>Objectives</b>
Pregnant women and their children within 1000 days of life	<ul style="list-style-type: none"> <li>• Appropriate amount of rest and intake of the right foods while pregnant and breastfeeding</li> <li>• Understanding and acceptance of breastfeeding within one hour after birth (colostrum providing basic needs to baby until milk comes in)</li> <li>• Increased use of exclusive breastfeeding during the first 6 months of life</li> <li>• Increased use of complimentary feeding from 6 months of age with continued breastfeeding until 2 years of age</li> <li>• Improved hygiene practices</li> <li>• Recognition of signs of illness and/or malnourishment for improved nutritional care of sick and malnourished children</li> <li>• Improved variety and quality of food and micronutrient supplementation to ensure adequate intake of vitamin A, iron, folic acid, zinc, and iodine for women and children</li> </ul>	<ul style="list-style-type: none"> <li>• Not enough widespread acceptance of the need to breastfeed the baby within the first hour and to exclusively breastfeed for 6 months.</li> <li>• Introduction of medicinal infusions</li> <li>• Substitution of breast milk with <i>atoles</i> and other liquids</li> <li>• Not enough food given out of fear of making the baby sick as the baby is not demanding more food</li> <li>• Inadequate food variety: fear that certain foods will make the baby sick</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of pregnant women who are determined to breastfeed their baby within the first hour, because they understand it will benefit their baby's health</li> <li>• Increased number of women who feel confident that breastfeeding exclusively for 6 months will improve the health of their babies.</li> <li>• Increased number of women who feel confident their child will grow stronger when feeding them greater amounts and more varied and nutritionally optimal foods from 6 months on</li> <li>• Increased number of women who identify signs of illness and malnutrition and take action before it becomes a severe case</li> </ul>

<b>Audience</b>	<b>Desired Changes</b>	<b>Barriers</b>	<b>Objectives</b>
Fathers of children within 1000 days of life	<ul style="list-style-type: none"> <li>• Increased participation in clinic and home visits, during which he inquires how to take care of and prevent malnutrition of children</li> <li>• Recognition of signs of illness and/or malnourishment for improved nutritional care of sick and malnourished children</li> <li>• Increased shared responsibility, increased discussion and planning with his partner/wife to improve the variety and nutritional quality of the family and hygiene in the household</li> <li>• Motivated to try new approaches to the diet and feeding of his children in order to maintain them healthy</li> </ul>	<ul style="list-style-type: none"> <li>• Social norms – no participation in child care</li> <li>• Links with family planning /direct influences on nutrition</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of men who encourage and support their wife’s exclusive breastfeeding for 6 months.</li> <li>• Number of fathers who feel that it is part of their duty as the father to actively participate in nutrition decisions.</li> <li>• Increased number of men who identify signs.</li> </ul>
Siblings who cares for children within 1000 days of life	<ul style="list-style-type: none"> <li>• Recognition of signs of illness and/or malnourishment for improved nutritional care of sick and malnourished children</li> <li>• Help the mother feed the 6 month baby appropriate quality and amounts of food</li> <li>Improved collaboration in</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge</li> <li>• Education level</li> <li>• Lack of motivation to take care of siblings and help mom;</li> <li>• Budget</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of siblings who know how to identify signs of illness and malnutrition and tell their parents</li> <li>• Increased number of siblings who are motivated to wash their hands and the baby’s hands before meals</li> <li>• Increased number of siblings who offer to help mom during meal times</li> <li>• Increased number of brothers/sisters who want to care for their siblings</li> </ul>

<b>Audience</b>	<b>Desired Changes</b>	<b>Barriers</b>	<b>Objectives</b>
Grandmothers	<ul style="list-style-type: none"> <li>• Use leading role to provide accurate advice to improve the family's nutrition and children's health.</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge not valuing the importance of exclusive breastfeeding</li> <li>• Social norms because of her age, she knows better Education level (barrier language)</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of grandmothers who provide <i>accurate</i> advice to improve the family's nutrition</li> </ul>
Midwives	<ul style="list-style-type: none"> <li>• Counseling mothers on use of colostrum in the first hour of birth</li> <li>• Sufficient knowledge and motivation to provide correct nutrition information about exclusive breastfeeding</li> <li>• Recognition of signs of illness and/or malnourishment</li> <li>• for improved nutritional care of sick and malnourished children</li> </ul>	<ul style="list-style-type: none"> <li>• Outdated nutritional information</li> <li>• Education level</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of midwives who report counseling mothers about feeding colostrum</li> <li>• Increased number of midwives who report counseling mothers about signs of illness and malnutrition</li> <li>• Increased number of midwives who can explain the benefits of exclusive breastfeeding</li> </ul>
Nurses (including nurse assistants)	<ul style="list-style-type: none"> <li>• Ensures use of colostrum</li> <li>• Increased collaboration and assertive communication</li> <li>• among health team members</li> </ul>	<ul style="list-style-type: none"> <li>• Work overload blocks active listening</li> <li>• Not client-oriented Self-esteem and how it is used in their position of</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of nurses who report counseling mothers about feeding colostrum</li> <li>• Increased number of nurses who follow counseling protocols for active listening and</li> </ul>

<b>Audience</b>	<b>Desired Changes</b>	<b>Barriers</b>	<b>Objectives</b>
Community agents/PEC/NGO volunteers	<ul style="list-style-type: none"> <li>• Promote use of exclusive breastfeeding during the first 6 months of life</li> <li>• Promote use of nutritionally optimal complimentary feeding from 6 months of age</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge</li> <li>• Education level</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of community agents who practice positive interpersonal communication skills to counsel clients on breastfeeding and nutrition</li> <li>• Increased number of community agents who report counseling patients on the benefits of exclusive breastfeeding</li> <li>• Increased number of community agents who provide accurate information on nutritionally optimal complimentary food options after 6 months of age</li> <li>• Increased number of community agents who become a trusted source of breastfeeding and nutrition information.</li> <li>Increased number of community agents who believe that fellow providers are trusted sources of breastfeeding and nutrition information</li> </ul>

<b>Audience</b>	<b>Desired Changes</b>	<b>Barriers</b>	<b>Objectives</b>
Doctors	<ul style="list-style-type: none"> <li>• Increased collaboration and assertive communication among health team members</li> <li>• Tailored explicit messages to women and community members regarding breastfeeding and optimal nutrition.</li> </ul>	<ul style="list-style-type: none"> <li>• Work overload blocks active listening</li> <li>• Not client-oriented</li> <li>• Language barriers</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of doctors who lead their teams to improve quality of services and coordination within the different components (including client orientation and language skills)</li> <li>• Increased number of doctors who take advantage of key opportunities to communicate specific messages to families about breastfeeding, optimal nutrition and hygiene in a clear and simple way</li> </ul>
Community leaders/elected officials/ COCODES, etc.	<ul style="list-style-type: none"> <li>• Increased collaboration and assertive communication among community members to achieve better hygiene and nutrition practices within the community</li> <li>• Demand appropriate community hygiene, supply of water and health services</li> <li>• Involve women in development of appropriate nutrition programming for women and child-focused program</li> <li>• Community and business leaders motivated to promote and support greater access to affordable and nutritious food options through community</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge Education level Economy (cheaper goods with no fortified nutrients, easier to sell)</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of community actors who communicate key messages to families about hygiene and nutrition in a clear and simple way</li> <li>• Increased number of community actors who take advantage of key opportunities to communicate key messages to families about hygiene and nutrition in a clear and simple way</li> <li>• Increased number of families who communicate with</li> </ul>

<b>Audience</b>	<b>Desired Changes</b>	<b>Barriers</b>	<b>Objectives</b>
	channels and markets. <ul style="list-style-type: none"> <li>Active engagement in specific actions to alleviate malnutrition,</li> </ul>		community actors about hygiene and nutrition <ul style="list-style-type: none"> <li>Increased number of community and business leaders who advocate for expanding affordable and nutritious food options.</li> </ul>
Churches		<ul style="list-style-type: none"> <li>Gaps</li> </ul>	
Schools	<ul style="list-style-type: none"> <li>Active engagement in specific actions to alleviate malnutrition,</li> <li>such as hygiene, nutrition literacy – in a memorable and clear way.</li> </ul>	<ul style="list-style-type: none"> <li>Lack of correct information on nutrition</li> <li>Lack of understanding of the relation between nutrition and student performance</li> <li>Lack of motivation to engage in other activities due to competing interests and shortage of time</li> <li><i>Tiendas</i> in school premises don't stock nutritional snacks</li> </ul>	<ul style="list-style-type: none"> <li>Increased number of teachers who communicate in a simple and clear manner with the school community about optimal nutrition and hygiene.</li> </ul>

### **Strategic Approach**

The strategic approach combines individual and family behavior change communication with social mobilization at the community level to increase demand for affordable and nutritious food options in indigenous communities. The strategy proposes SBCC interventions at the household level and community levels to

improve the quality, content, and cultural appropriateness of optimal breastfeeding and complementary feeding practices for mothers, influential supporters within the family and community, and health care providers.

This will be complemented by SBCC interventions to increase demand for affordable and nutritious food options by improving the nutrition literacy of indigenous consumers, health care providers capacity to provide appropriate nutrition counseling; motivate community and business leaders to promote nutrition through community channels and markets; advocacy for greater investment/support to the agriculture /food value chains.

## Positioning

**The community working together for improved hygiene and nutrition will reduce poverty, facilitate growth and boost community development.**

### Key Information

Pregnant women and their children within 1000 days of life	<ul style="list-style-type: none"> <li>• Importance of resting and eating right while pregnant and breastfeeding</li> <li>• Colostrum provides basic needs to baby until milk comes in</li> <li>• Seven essential nutrition actions:</li> <li>• Breastfeeding provides baby with all nutrition s/he needs during the first 6 months of life</li> <li>• Importance of complimentary feeding from 6 months of age with continued breastfeeding until 2 years of age</li> <li>• Appropriate balanced diet ; plates for kids</li> <li>• Feeding during illness. Appropriate hygiene practices and food/water storage</li> <li>• Signs of illness and/or malnourishment</li> <li>• Improved variety of food and micronutrient supplementation to ensure adequate intake of vitamin A, iron, folic acid, zinc, and iodine for women and children</li> </ul>
Fathers of children within 1000 days of life	<ul style="list-style-type: none"> <li>• Motivated to care for the mother while she is pregnant</li> <li>• Father share or participate in assuring that food consumed at home is varied and has basic nutrient supplements</li> <li>• Man's duty to participate actively taking care of his family's nutritional needs/health</li> </ul>



<b>Key Information</b>	
	<ul style="list-style-type: none"> <li>• Dad needs to know signs of illness in order to protect his children</li> <li>• 7 essential nutrition actions</li> </ul>
Siblings who cares for children within 1000 days of life	<ul style="list-style-type: none"> <li>• Recognition of signs of illness</li> <li>• Helping mother in the household, including helping feed the 6 month old baby, helps mom be happier and take better care of the family</li> <li>• Having the sentiment that I'm a good brother/sister because I care for my little brothers and sisters.</li> <li>• 7 essential nutrition actions</li> </ul>
Grandmothers	<ul style="list-style-type: none"> <li>• Grandmother plays an important role to improve the nutrition habits that will keep her grandchildren healthy</li> </ul>
Midwives	<ul style="list-style-type: none"> <li>• Importance of colostrum for a healthy post natal period</li> <li>• Correct nutrition information for newborns up to 2 years of age</li> <li>• Self-esteem and motivation (as agent of change). I have the capacity to influence the</li> <li>• Families and improve their health.</li> <li>• New information helps me be a better midwife and/or support to the families.</li> <li>• Seven essential nutrition actions</li> </ul>
Nurses (including nurse assistants)	<ul style="list-style-type: none"> <li>• Importance of colostrum</li> <li>• Correct information about breastfeeding and nutrition</li> <li>• Appropriate hygiene and food/water storage practices</li> <li>• Assertive two-way communication/ active listening</li> <li>• Teamwork</li> <li>• Signs of illness to communicate to their clients</li> </ul>
Community agents/PEC/NGO volunteers	<ul style="list-style-type: none"> <li>• Importance of colostrum</li> <li>• Correct information about breastfeeding and nutrition</li> <li>• Appropriate hygiene and food/water storage practices</li> <li>• When I use active listening techniques, it will motivate the mother to ask questions (<i>If I am a better counselor, it will make my work easier and more successful.</i>)</li> <li>• Suggestions, not orders are more likely to promote change</li> <li>• Seven essential nutrition actions</li> </ul>
Doctors	<ul style="list-style-type: none"> <li>• Client oriented services are the key to success. Tailored messaging around optimal nutrition and breastfeeding practices.</li> <li>• Teamwork will bring success</li> </ul>
Community leaders/elected officials/ COCODES,	<ul style="list-style-type: none"> <li>• Nutrition Literacy</li> <li>• Promotion of nutrition through community channels and markets</li> </ul>

<b>Key Information</b>	
etc.	<ul style="list-style-type: none"> <li>• Appropriate food and water storage</li> <li>• Assertive communication</li> <li>• Teamwork</li> <li>• Seven essential nutrition actions: how to operationalize them in your area.</li> </ul>
Churches	[Gap]
Schools	<ul style="list-style-type: none"> <li>• Correct information about breastfeeding and nutrition: school curriculum</li> <li>• Appropriate hygiene and food/water storage practices</li> <li>• Seven essential nutrition actions.</li> </ul>

<b>Channels, Activities and Materials</b>	
Pregnant women and their children within 1000 days of life	<ul style="list-style-type: none"> <li>• Interpersonal Channels (peer education, home visits)</li> <li>• Radio: spots, soap operas, talk shows</li> <li>• Use of available technology creatively (IT-mobile telephone)</li> <li>• Information tables in markets, town festivals</li> <li>• Church meetings</li> <li>• Visit to health posts/PEC</li> </ul>
Fathers of children within 1000 days of life	<ul style="list-style-type: none"> <li>• Radio spots – better during soccer</li> <li>• Community radio talk shows combined with other topics, such as agriculture</li> <li>• Billboards</li> <li>• Posters in the ‘cantina’</li> <li>• Interpersonal activities</li> <li>• Home visits that include discussions with the couple</li> <li>• Fairs</li> <li>• Agricultural group meetings, other meetings of men</li> </ul>
Siblings who cares for children within 1000 days of life	<ul style="list-style-type: none"> <li>• Songs (school, radio)</li> <li>• Games (school, <i>feria del pueblo</i>, church) Classes for child-child learning</li> </ul>
Grandmothers	<ul style="list-style-type: none"> <li>• Interpersonal channels (Peer educators home visits)</li> <li>• Radio: spots, soap operas, talk shows</li> <li>• Use of available technology creatively (IT - mobile telephone)</li> <li>• Information tables in markets, town festivals</li> <li>• Church meetings</li> </ul>
Midwives	<ul style="list-style-type: none"> <li>• Peer education Interpersonal channels Home visits</li> <li>• Church visits</li> <li>• Clinic</li> </ul>
Nurses (including nurse	<ul style="list-style-type: none"> <li>• Client-oriented seminars</li> </ul>

<b>Channels, Activities and Materials</b>	
assistants)	<ul style="list-style-type: none"> <li>• Team-building activities</li> <li>• Training &amp; role playing – active listening, tailoring offer of products and services</li> </ul>
Community agents/PEC/NGO volunteers	<ul style="list-style-type: none"> <li>• Training &amp; role playing – active listening, tailoring messages, recommendations and referrals</li> <li>• Meetings and discussions with community providers to search for common interests and mutual benefits when working together</li> </ul>
Doctors	<ul style="list-style-type: none"> <li>• Client-oriented seminars</li> <li>• Team-building activities</li> <li>• Training &amp; role playing – active listening, tailoring offer of products and services</li> </ul>
Community leaders/elected officials/ COCODES, etc.	<ul style="list-style-type: none"> <li>• Training: empowerment</li> <li>• Community dialogues</li> <li>• Advocacy through media, forums</li> </ul>
Churches	<ul style="list-style-type: none"> <li>• [Gap]</li> </ul>
Schools	<ul style="list-style-type: none"> <li>• Songs (school, radio)</li> <li>• Fun and innovative activities for children</li> <li>• Games (school, <i>feria del pueblo</i>, church)</li> <li>• Teachers training days Child-Child programming Community dialogue</li> </ul>



**USAID** | **GUATEMALA**  
FROM THE AMERICAN PEOPLE

**C-CHANGE**   
COMUNICACIÓN PARA EL CAMBIO

# Social Behavior Change Communication Strategy

USAID/Guatemala

Health and Education Office

# HIV/AIDS

October 2011

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## 7. SUMMARY OF ANALYSIS

### *Problem Statement*

Most at risk populations (MARP) and people living with HIV/AIDS (PLHIV) clients are reluctant to attend public health clinics because of the stigmatizing and discriminating treatment they receive. This reinforces the clients' low self-esteem and results in poor health monitoring, higher morbidity and mortality rates. Health care providers are poorly trained in the area of HIV/AIDS and client-oriented services, and are unaware of the relevant human rights issues. This situation blocks access to the continuum of care for each of the populations considered MARP as well as for those who are living with HIV/AIDS.

Local community leaders, churches and schools place a low priority on quality HIV/AIDS services. Local NGOs representing MARP and PLHIV work in prevention activities and provide volunteer staffing in the local health offices and act as a link between their members and service providers, promoting better services in the 8 regions most affected by HIV/AIDS.

### *Information/Research Gaps*

- Updated mapping of local human rights associations
- Updated mapping of men who have sex with men (MSM), transgender and female sex workers (FSW) hot spots in departmental urban areas
- Updated mapping of HIV/STI related services
- Need to link family planning and HIV services in the Western Highlands.

### *Required Changes*

- Reduced stigma and discrimination levels between MARP and PLHIV and health care providers, local community leaders, churches and schools that are involved in the continuum of services, from prevention to care
- Creation of proactive multi-sectoral networks at the local level. (Local health office, local NGOs representing MARP and PLHIV, IGSS, civil society representatives (firemen, police)) mobilizing the community for improved access to prevention and care services.

- Maintain/develop national HIV/AIDS policies, regulations and awareness-driven activities that create a supportive environment for quality HIV/AIDS services in the 8 regions of Guatemala that have reported HIV/AIDS cases.
- MARP and PLHIV exhibiting assertive health seeking behavior.
- Improve quality of care through improved counseling and interpersonal skills of health providers in order to provide quality services to PLWHIV/AIDS, FSW, MSW, transgender, and gay people.
- Improve private-public alliances in critical areas such as policies, laws, and protocols at the local level, for example with big employers such as the sugar industry.
- Support National Strategic Planning Process. A multi-sectoral approach that emphasizes the participation and strengthening of civil society's capacity to respond to the epidemic through strategic use of information for advocacy, policymaking, and M&E of program efforts
- Shift social norms from traditional male gender norms towards more egalitarian ones

### Theory of Changes

#### *Tipping points:*

- MARP and PLHIV exhibiting assertive health seeking behavior
- Proactive Multi-sectoral networks
- Funding of health costs

We expect that creating proactive multi-sectoral networks will provide an important tipping point for change. The concept that these assumptions are based on can be found in the related theories: **Social networking and social capital theories** describe how to strengthen and motivate networks for action. The **integrated model of communication for social change** can guide a process of community dialogue leading to collective action to act as a catalyst; **community organization** with key concepts of community capacity to perform critical tasks, participation and self-determination and relevance, public commitment, organized diffusion and critical mass.

We also expect that MARP and PLHIV exhibiting assertive health seeking behavior will help move the tipping point for change in reducing stigma and discrimination for people seeking treatment in public hospitals. The concept that these assumptions are based on are used in **social learning theories** to increase self-efficacy as well as in the **theory of social norms** to address social norms, collective norms, perceived norms and stigma;. Client provider models will help to guide intrapersonal factors and interpersonal processes related to assertive health seeking behavior.



## 8. COMMUNICATION STRATEGY

<i>Final audience segmentation</i>		
Users	MSM	<i>Directly Affected.</i> They need access to the services
	Transgender	<i>Directly Affected.</i> They need access to the services including human rights and advocacy
	Female sex workers and their clients	<i>Directly Affected.</i> They need access to the services
	PLHIV	<i>Directly Affected.</i> They need access to the services
	Adolescents	<i>Directly Affected.</i> They need access to prevention and care services
Suppliers	Health care providers	<i>Direct Influencers.</i> They lower barriers to service use advocate for and promote human rights
	Community leaders	<i>Direct Influencers.</i> They advocate for and promote human rights
	NGOs	Direct Influencers. They advocate for and promote human rights and have the capacity to reach target populations
	Multi-sectoral networks [Local health office, local NGOs representing MARP and PLHIV, IGSS, civil society representatives (firemen, police)]	<i>Direct Influencers.</i> Networks identify problems and look for solutions that make sense for their local setting, low investment, and could promote great local programming (e.g. Coatepeque)
	Private sector (FUNDAZUCAR, ingenios, store/bar/cantina owners and	<i>Direct Influencers.</i> Member multi-sectoral network; important allies to provide the space for implementing promotion and education activities with target populations

	administrators)	
	MoH national heads	<i>Indirect Influencer.</i> Member multi-sectoral network; need to sensitize; they have the ability to enforce respect for human rights
	MoH departmental heads	<i>Indirect Influencer.</i> Member multi-sectoral network; need to sensitize; they have the ability to enforce respect for human rights
	Local Authorities: Governors and mayors in the departmental capital	<i>Direct Influencers.</i> Member multi-sectoral network; need to sensitize; they have the ability to create/implement human rights related policy, regulations and promotion

<b>Audience</b>	<b>Desired Changes</b>	<b>Barriers</b>	<b>Objectives</b>
MSM	<ul style="list-style-type: none"> <li>To know and demand their rights</li> <li>To continue attending health services regardless of human rights violations suffered</li> <li>To denounce human rights violations</li> <li>To know their responsibilities</li> </ul>	<ul style="list-style-type: none"> <li>Lack of access to accurate information about their rights in relation to the health care system</li> <li>Low self-esteem to address the potential risk of HIV or self-care in the case of being infected</li> </ul>	<ul style="list-style-type: none"> <li>Increased number of PLHIV and MARPs who know where to go to seek support and/or denounce human rights violations</li> </ul>
Transgender	<ul style="list-style-type: none"> <li>To know and demand their rights</li> <li>To continue attending health services regardless of human rights violations suffered</li> <li>To denounce human rights violations</li> <li>To know their responsibilities</li> </ul>	<ul style="list-style-type: none"> <li>Lack of accurate information on HIV</li> <li>Misconceptions about MARPs and living with HIV</li> <li>Lack of access to accurate information about their rights in relation to the health care system</li> <li>Low self-esteem to address the potential risk of HIV or self-care in the case of</li> </ul>	<ul style="list-style-type: none"> <li>Increased number of PLHIV and MARPs who know where to go to seek support and/or denounce human rights violations</li> <li>Increase number of PLHIV and MARP who feel that they can make a difference in their</li> </ul>

<i>Audience</i>	<i>Desired Changes</i>	<i>Barriers</i>	<i>Objectives</i>
		<ul style="list-style-type: none"> <li>being infected</li> <li>• Low Social economic status (SES)</li> <li>• Education level</li> <li>• Violation of human rights from authorities</li> </ul>	<ul style="list-style-type: none"> <li>lives by reporting human rights violations</li> </ul>
Female sex workers and their clients	<ul style="list-style-type: none"> <li>• To know and demand their rights</li> <li>• To continue attending health services regardless of human rights violations suffered</li> <li>• To denounce human rights violations</li> <li>• To know their responsibilities</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of access to accurate information about their rights in relation to the health care system</li> <li>• Low self-esteem to address the potential risk of HIV or self-care in the case of being infected</li> <li>• Low SES</li> <li>• Education level</li> <li>• Violation of human rights</li> <li>• no follow-up</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of PLHIV and MARPs who know where to go to seek support and/or denounce human rights violations</li> <li>• Increase number of PLHIV and MARP who feel that they can make a difference in their lives by reporting human rights violations</li> </ul>
PLHIV	<ul style="list-style-type: none"> <li>• To know and demand their rights</li> <li>• To continue attending health services regardless of human rights violations suffered</li> <li>• To denounce human rights violations</li> <li>• To know their responsibilities</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of access to accurate information about their rights in relation to the health care system.</li> <li>• Low self-esteem to address the potential of self-care and demand services</li> <li>• Middle to low SES</li> <li>• Middle to low education level</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of PLHIV and MARPs who report knowing where to go to seek support and/or denounce human rights violations</li> <li>• Increase number of PLHIV and MARP who feel that they can make a difference in their lives by reporting human rights violations (self-efficacy)</li> </ul>
Adolescents	<ul style="list-style-type: none"> <li>• Adolescents have capacity and information to stop</li> </ul>	<ul style="list-style-type: none"> <li>• Conservative culture barriers</li> <li>• Have limited</li> </ul>	<ul style="list-style-type: none"> <li>• Schools inform and educate young people</li> </ul>

Audience	Desired Changes	Barriers	Objectives
	<p>the HIV epidemic.</p> <ul style="list-style-type: none"> <li>Adolescents aware of the ways of preventing HIV infection</li> <li>Adolescents are educating their family and friends about HIV</li> <li>To reduce youth risk factors in the formal education system, strengthening the adoption of healthy behavior, skills and knowledge that contribute to improving the quality of personal life, family and community.</li> </ul>	<p>knowledge about HIV, because society does not facilitate obtaining accurate information</p> <ul style="list-style-type: none"> <li>Sexual education depends on adults criteria</li> <li>Stigma and discrimination prevent them from talking freely about HIV and sexuality</li> <li>Negative attitudes toward the most vulnerable groups (stereotypes)</li> </ul>	<p>about HIV, STIs and sexuality.</p> <ul style="list-style-type: none"> <li>Increase number of adolescents who describe modes of prevention of HIV and STIs</li> </ul>
Health care providers	<ul style="list-style-type: none"> <li>Offer a courteous welcoming and appropriate and pertinent information to clients</li> <li>Provide client-oriented services</li> <li>Knowledgeable about the HIV/AIDS protocols for prevention and care in their health care setting</li> </ul>	<ul style="list-style-type: none"> <li>Rejection/Prejudices: stereotypes about gays, transgender and sex workers</li> <li>Poor education and poor training</li> <li>Gaps in Knowledge of STI/HIV</li> <li>Beliefs that are stigmatizing (<i>you will try to seduce me</i>)</li> <li>Disrespectful of patient confidentiality and privacy in health centers</li> <li>STI centers not trained in HIV</li> </ul>	<ul style="list-style-type: none"> <li>Increased number of HIV/AIDS related services motivated and skilled to provide a courteous welcome and accurate and pertinent information to PLHIV and MARPs (MSM, transgender, FSW)</li> <li>Increase number of PLHIV and MARPs who report positive provider-client interaction at HIV/STI health facilities</li> <li>Increased number of providers who become a trusted</li> </ul>

<i>Audience</i>	<i>Desired Changes</i>	<i>Barriers</i>	<i>Objectives</i>
Community leaders	<ul style="list-style-type: none"> <li>• Promote HIV/AIDS discussions among the community leaders and committees</li> <li>• Active participation in multi-sectoral networks</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge on STI/HIV/AIDS in general</li> <li>• Prejudices: stereotypes about MSM, transgender and FSW</li> <li>• Don't see how it relates to their world and their role as community leaders.</li> </ul>	<p>source for HIV/STI services</p> <ul style="list-style-type: none"> <li>• Increased number of community leaders skilled in identifying and addressing stigma among themselves and their community members</li> <li>• Increased number of community leaders who communicate key messages to their communities about HIV and human rights</li> <li>• Increased number of community actors who take advantage of key opportunities to communicate messages to their communities about HIV and human rights in a clear and simple way</li> <li>• Increased number of community leaders who communicate with community actors about HIV and human rights</li> </ul>
NGOs	<ul style="list-style-type: none"> <li>• Reach more distant populations in a culturally appropriate way</li> <li>• Include MARPS and PLHIV on strategies for prevention, treatment, care</li> </ul>	<ul style="list-style-type: none"> <li>• Geographic scope</li> <li>• Not enough knowledge of the target populations at the local site, make assumptions about their options</li> </ul>	<ul style="list-style-type: none"> <li>• Increase number of local NGOs that include human rights awareness and skills building in their programming</li> <li>• Increase the number of local NGOs who reach</li> </ul>

<b>Audience</b>	<b>Desired Changes</b>	<b>Barriers</b>	<b>Objectives</b>
			more and more distant populations in a culturally appropriate way with strategies for prevention, treatment and care
Multi-sectoral networks [Local health office, local NGOS representing MARP and PLHIV, IGSS, civil society representatives (firemen, police)]	<ul style="list-style-type: none"> <li>• Support the process of HIV prevention and information sharing to the community</li> <li>• Promote local HIV related programming</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge on STI/HIV/AIDS in general and its specific relevance to their community.</li> <li>• Prejudices: stereotypes about MSM, transgender and FSW</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of local multi-sectoral networks that include MARP and PLHIV in decision making process</li> </ul>
Private sector (FUNDAZUCAR, <i>ingenios</i> , store/bar/ <i>cantina</i> owners and administrators)	<ul style="list-style-type: none"> <li>• Support and involvement in the process of HIV prevention and information to the community</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge on STI/HIV/AIDS in general and it's relevance to their services</li> <li>• Prejudices: stereotypes about MSM, transgender and FSW</li> </ul>	<ul style="list-style-type: none"> <li>• Active engagement in specific actions to promote HIV prevention and human rights, such as inclusion of education and promotional activities within their businesses</li> <li>• Dialogue with community leaders and elected officials to maximize collaboration</li> </ul>
MoH departmental heads	<ul style="list-style-type: none"> <li>• Coordinate actions of prevention, treatment and care continuum for HIV.</li> <li>• Create human rights policies and regulations</li> </ul>	<ul style="list-style-type: none"> <li>• No communication among civil society organizations working in HIV and the MoH</li> <li>• MoH prioritizes support contingent upon emergencies</li> <li>• HIV ranks #8 within national health priorities</li> </ul>	<ul style="list-style-type: none"> <li>• Increased number of national authorities who support and participate in the process of HIV/AIDS prevention and care</li> </ul>

<i>Audience</i>	<i>Desired Changes</i>	<i>Barriers</i>	<i>Objectives</i>
Local authorities: governors and mayors in the departmental capital	<ul style="list-style-type: none"> <li>Support the initiatives of multi-sectoral networks and community leaders.</li> <li>Create links between communities and national authorities</li> </ul>	<ul style="list-style-type: none"> <li>HIV not part of the political agenda</li> <li>Targetted populations not prioritized</li> <li>Competing priorities in the municipality</li> <li>No structure for reaching youth systematically</li> </ul>	<ul style="list-style-type: none"> <li>Increased number of local authorities who support and participated in the process of HIV prevention and care.</li> <li>Increased number of local authorities who include MARP and PLHIV in decision making process.</li> </ul>

### *Strategic Approach*

Reducing stigma and discrimination will increase the number of satisfied MARPs and PLHIVs attending health services as well as increase health seeking behaviors among those not accessing services yet. A reduction in stigma and discrimination between health providers and MARPs can be achieved using the following strategies:

- Awareness/ human rights and IPC skills training and monitoring of health care providers
- Capacity building of the self-help groups and local networks of MARP
- Increase the quality and quantity of positive media coverage of the networks and institutions involved in decreasing stigma and discrimination
- Advocacy to involve private sector employers in supporting the continuum of services from prevention testing to care for their employees
- Shifting of social norms from male gender oriented norms towards more egalitarian norms

### *Positioning*

The strategic focus is that “WE’RE DIFFERENT BUT EQUAL IN RIGHTS AND OBLIGATIONS”.

### *Key Information*

MSM	<ul style="list-style-type: none"> <li>Human rights</li> </ul>
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<b>Key Information</b>	
	<ul style="list-style-type: none"> <li>• Stigma and discrimination / abandoning treatment and other consequences</li> </ul>
PLHIV	<ul style="list-style-type: none"> <li>• Self-efficacy/ benefits of NOT abandoning treatment and rather demanding deserved services</li> </ul>
Female sex workers and their clients	<ul style="list-style-type: none"> <li>• Human rights support organization and services (referrals)</li> <li>• Assertive communication techniques/active listening</li> </ul>
Transgender	
Adolescents	<ul style="list-style-type: none"> <li>• Updated and accurate information about HIV, STIs and Sexuality</li> <li>• Non-discriminatory language</li> <li>• Self-efficacy</li> <li>• Safe sex negotiation technics</li> <li>• Human Rights: stigma and discrimination</li> <li>•</li> </ul>
Health care providers	<ul style="list-style-type: none"> <li>• Human rights</li> <li>• Legal situation</li> <li>• Updated terminology on HIV</li> <li>• Non-discriminatory language</li> <li>• Stigma and discrimination/ abandoning treatment and other consequences</li> <li>• Epidemiological factors</li> <li>• Client-oriented services</li> <li>• Active listening</li> <li>• Training in clinical protocols for MARP and PLHIV</li> </ul>
Community leaders	<ul style="list-style-type: none"> <li>• Human rights awareness &amp; training</li> <li>• Stigma and discrimination/ abandoning treatment and other consequences</li> </ul>
NGOs	<ul style="list-style-type: none"> <li>• Non-discriminatory language</li> <li>• <i>Let's work together on this. Get involved!</i></li> </ul>
Multi-sectoral networks [Local health office, local NGOS representing MARP and PLHIV, IGSS, civil society representatives (firemen, police)]	
Private sector (FUNDAZUCAR,	



<b>Key Information</b>	
<i>ingenios</i> , store/bar/ <i>cantina</i> owners and administrators)	
MoH national heads	<ul style="list-style-type: none"> <li>• Human rights</li> <li>• Legal situation</li> <li>• Updated terminology on HIV</li> <li>• Non-discriminatory language</li> <li>• Stigma and discrimination/ abandoning treatment and other consequences</li> <li>• Epidemiological factors</li> </ul>
MoH departmental heads	
Local authorities: governors and mayors in the departmental capital	

<b>Channels, Activities and Materials</b>	
MSM	Target-population-specific: <ul style="list-style-type: none"> <li>• Peer outreach</li> <li>• Unofficial prevention/wellness parties</li> <li>• Support materials such as               <ul style="list-style-type: none"> <li>○ Flyers</li> <li>○ Photos with messaging</li> <li>○ Key-chains with messaging</li> <li>○ Radio spots/jingles (general population oriented)</li> </ul> </li> <li>• PLHIV and MARP community or network meetings with role playing/ self-efficacy use of interactive support materials</li> </ul>
Transgender	
Female sex workers and their clients	
PLHIV	
Adolescents	<ul style="list-style-type: none"> <li>• Artistic activities as street theater, concerts, fairsPeer outreach</li> <li>• Champions</li> <li>• Approach to Marps</li> <li>• Radio/TV programs</li> <li>• Promotional items such as T-shirts, hats, water bottles, sport balls</li> <li>• Visits to local clinics</li> <li>• Conferences about sexuality, HIV prevention and care, respect to diversity, etc</li> </ul>

<b>Channels, Activities and Materials</b>	
	•
Health care providers	<ul style="list-style-type: none"> <li>• Human rights seminars</li> <li>• Testimonies of PLHIV and MARP as well as successful providers for these populations</li> <li>• Training (stigma and discrimination/ consequences for health, nondiscriminatory language)</li> <li>• Role playing (experiencing discrimination)</li> <li>• Pocket support materials on clinical protocols for MARP and PLHIV</li> </ul>
Community leaders	<ul style="list-style-type: none"> <li>• Human rights seminars</li> <li>• Visits to businesses &amp; associations</li> <li>• Promotional items, such as mugs, calendars, calculators, t-shirts and hats</li> </ul>
NGOs	
Multi-sectoral networks [Local health office, local NGOS representing MARP and PLHIV, IGSS, civil society representatives (firemen, police)]	
Private sector (FUNDAZUCAR, <i>ingenios</i> , store/bar/ <i>cantina</i> owners and administrators)	
MoH national heads	<ul style="list-style-type: none"> <li>• Human rights seminars</li> <li>• Training (stigma and discrimination/ consequences for health, nondiscriminatory language)</li> <li>• Dialogue with human rights associations</li> <li>• Support desk materials addressing stigma</li> </ul>
MoH departmental heads	
Local authorities: governors and mayors in the departmental capital	