A TOOL FOR SBC PRACTITIONERS

Expanding the "S" in Social and Behavior Change:

Addressing Social Determinants of Health and Health Equity in SBC Programming

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Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

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Acronyms

CCP	Johns Hopkins Center for Communication Programs
CSO	Civil society organization
FP/RH	Family planning and reproductive health
HIP	High impact practices
M&E	Monitoring and evaluation
SBC	Social and behavior change
SDOH	Social determinants of health
TAG	Technical advisory group
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

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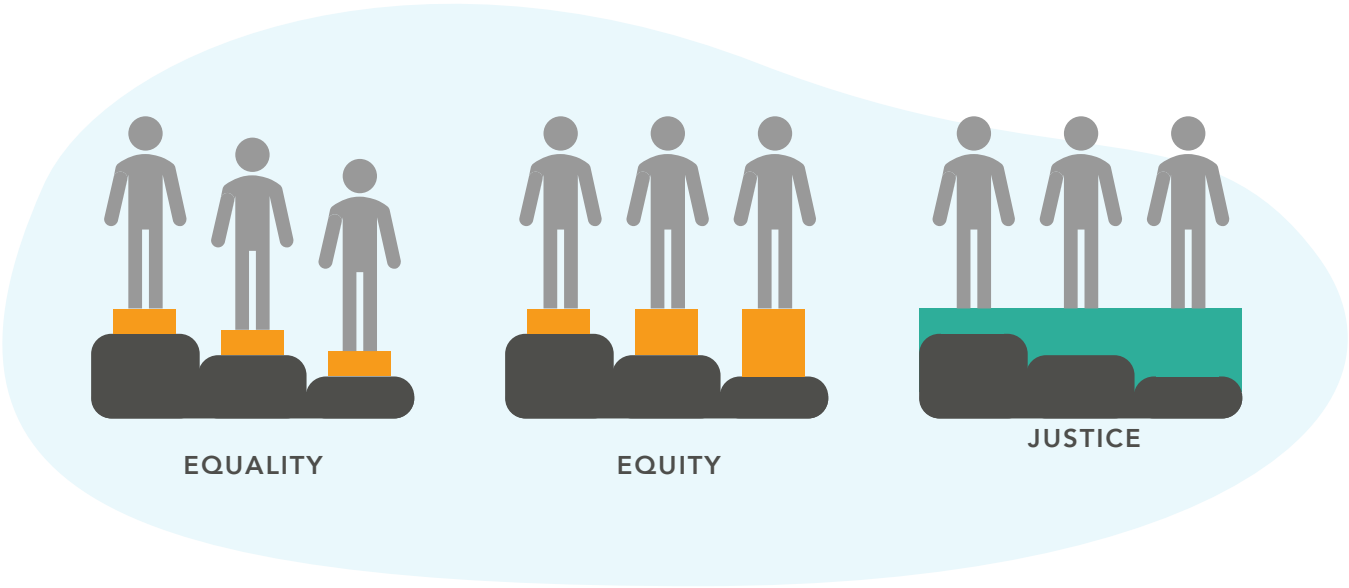


Introduction: Why Expand the "S" in Social and Behavior Change?

Background

To date, social and behavior change (SBC) interventions have focused primarily on identifying and shifting or maintaining recommended *behaviors* among individuals, households, groups, and communities by promoting behavior change and addressing intermediate factors that influence behavior, such as knowledge, attitudes, beliefs, and social and gender norms.[1] While these behavioral factors contribute to improved outcomes, SBC practitioners need to pay equal attention to expanding the "S" in SBC to create more equitable conditions within and across societies. By incorporating a social justice lens, the SBC community has the opportunity to wrestle with how best to acknowledge and address systemic problems inhibiting health outcomes while ensuring every person has an equal chance to participate in the decisions that affect them.[2,3]

Focusing on the 'social' aspect of SBC means identifying and addressing the root causes of inequities within which behavior change occurs.[4,5] A great deal of evidence shows persistent health inequities[6] are shaped by a combination of ***structural inequities***, the systemic advantages or disadvantages one group may have over another, and ***social determinants of health*** (SDOH), the situations, forces, and systems that shape an individual's daily living conditions.[7] The impact of SDOH on health and well-being is significant. Studies suggest SDOH impact between 30–55% of health outcomes.[8] Globally, unfair distribution of power and resources combines with structural inequities and SDOH to generate and sustain health inequities. Thus, expanding the "S" in SBC calls for structural and social change by redistributing power and resources across economic, political, and social systems to generate *more equitable conditions for all*.

Health Equity

The World Health Organization (WHO) defines *health equity* as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."[8]

Health Inequities

"Health inequities are systematic differences in the health status of different population groups" as defined by WHO.[6] Whitehead (2006, 1992) adds more nuance noting that these are "differences which are unnecessary and avoidable, but in addition are considered unfair and unjust."[9,10]

Social Determinants of Health

WHO defines *social determinants of health* as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems."[11] They can include access to safe water and housing; the quality of schools, workplaces, and neighborhoods; and the composition of social networks, and in general, reflect how people experience advantages and disadvantages over one another.[4]

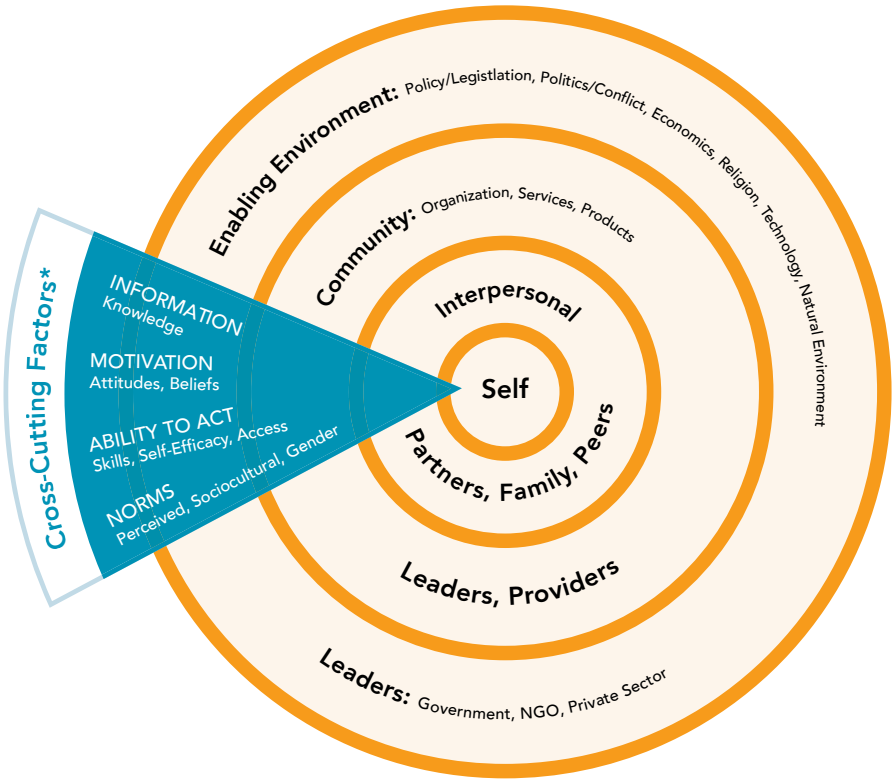
Structural Inequities

Factors such as racism, sexism, classism, ableism, xenophobia, homophobia, and transphobia, which condition people's social position within society and impact their access to opportunities and resources.[4]

In recent years, global health practitioners and researchers have made inroads considering and addressing SDOH and health equity in family planning and reproductive health (FP/RH) programming.[12] For example, they have designed multi-level, norms-shifting interventions in collaboration with multi-sector partners and stakeholders to influence systems and structures at higher levels of the socio-ecological model (*Figure 1*). In doing so, the SBC field has begun to more actively focus on social and structural factors to address structural inequities and SDOH. Despite progress in this area, the application of SDOH to SBC programming to improve health equity is still largely unknown.[13] Only by explicitly and systematically considering and addressing SDOH and health equity in the design, implementation, monitoring, and evaluation of interventions can SBC researchers, practitioners, and funding organizations truly expect to bring about equitable structural and social change.

Figure 1

Socio-Ecological Model for Change[14]



*These concepts apply to all levels (people, organizations, and institutions). They were originally devleoped for the individual level.

Figure 1. Adapted from McKee, N., Manoncourt, E., Yoon, C. S., & Carnegie, R. (Eds.). (2000). Involving people, evolving behavior. *New York: UNICEF; Penang: Southbound.*

This work will require creative thinking and innovation, as well as a more systems-oriented and complexity-aware lens. Targeted and effective advocacy and strategic coordination with government institutions, civil society organizations (CSOs), affected populations, private sector entities, media organizations, implementing partners, and funding organizations are critical for not only *influencing* but also *shifting* structures and systems to generate more equitable conditions for all. With the right guidance and tools, the SBC field can both identify opportunities for intervention and create them where they do not exist.

Purpose

Given that SBC practitioners are in the early stages of intentionally and consistently applying SDOH to SBC programming to support health equity,[13] this document serves as a thinking tool for practitioners as they consider how to identify, prioritize, and address social determinants in their programming. As such, viewed through a social justice lens, this tool offers key considerations and illustrative actions for advancing structural and social change with the aim of improving health equity through SBC programming that engages diverse partners and stakeholders across different sectors. It also highlights examples from the field of FP/RH in recognition of the important progress made within the international FP community in recent years.[12] Although the tool focuses on FP/RH, its content is broadly applicable to SBC programming across any health and development area.

Development Process

To develop this tool, Breakthrough ACTION conducted a rapid literature review of models and frameworks for understanding and addressing SDOH and health equity as well as interventions for addressing the same with a focus on FP/RH. The literature review deepened an understanding of the building blocks of health inequities and ways to address them across diverse global contexts. To ground this tool in SBC practice, Breakthrough ACTION convened a technical advisory group (TAG) composed of SBC and public health practitioners who work with international nongovernmental organizations, government institutions, and CSOs to implement SBC interventions to improve health and social outcomes across the globe. The TAG provided feedback through periodic document reviews and meetings, helping to refine key areas and content for the present tool.

Operationalizing a Framework to Address the Social Determinants of Health and Health Equity

WHO recognizes that the differences in access to (opportunity) and control over (power) resources lead to disparate and unequal health opportunities and outcomes around the world. As such, WHO has led efforts to more intentionally consider and address SDOH and health equity in global health programming. Launched in 2005, the WHO Commission on Social Determinants of Health espouses the following three principles of action for addressing health inequity:[15]

1. Improve the conditions of daily life: the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce trained in the social determinants of health, and raise public awareness about the social determinants of health.

This tool echoes these principles for addressing health inequity while also embracing a particular framework for considering SDOH. Healthy People 2030, developed by the Office of Disease Prevention and Health Promotion of the United States Department of Health and Human Services, is one of many frameworks informed by WHO's ongoing efforts.[16] Healthy People 2030 groups SDOH into the following five domains to capture the universe of health, functioning, and quality of life (*Figure 2*):

1. Economic Stability
2. Education Access and Quality
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

Figure 2

Social Determinants of Health: Five Key Domains[17]

Education Access and Quality

Access to high-quality educational opportunities

Examples: language and literacy, early childhood development and education, high school graduation, educational scholarships, higher education enrollment and retention

Health Care Access and Quality

Access to comprehensive, high-quality health care services

Examples: primary care access, universal health coverage, comprehensive health insurance, health literacy

Economic Stability

Access to resources to meet and exceed basic needs

Examples: employment and vocational support and opportunities, career counseling, high-quality childcare, housing stability, social assistance (e.g., cash assistance, housing subsidies, food assistance)

Social and Community Context

Access to social and community support

Examples: community cohesion (e.g., mutual aid), social inclusion, civic participation and empowerment, inclusive governance structures and processes (e.g., community dialogues, neighborhood associations), violence prevention and response initiatives

Neighborhood and Built Environment

Access to neighborhoods and environments that promote health and safety

Examples: environmental conditions (air and water quality), housing quality, food security, telecommunications and internet availability, neighborhood safety, physical activity opportunities, crime and violence

Figure 2. Adapted from Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. (n. d.). Social determinants of health. *https://health.gov/healthypeople/objectives-and-data/social-determinants-health*

This tool leverages the work of WHO and Healthy People 2030 to guide SBC practitioners as they consider how to identify, prioritize, and address SDOH and improve health equity through SBC programming focused on FP/RH. SBC programs particularly must address poverty and the priorities and needs of people living in poverty.

> **Poverty** remains the "single largest determinant of health, and ill health is an obstacle to social and economic development. Poorer people live shorter lives and have poorer health than affluent people. This disparity has drawn attention to the remarkable sensitivity of health to the social environment."[18]

Poverty increases vulnerability and exposure to high-risk conditions because it negatively impacts access to resources, opportunities, and conditions for "the enjoyment of the highest attainable standard of physical and mental health" in any given environment, otherwise known as the *right to health*.[19] How poverty is defined and experienced varies from place to place,[20] requiring a context-specific understanding of what qualifies as living in poverty, what drives poverty and inequality, and what priorities and needs exist around social support services and safety nets.

To better understand how individuals experience poverty in a given environment and how poverty influences vulnerability and exposure, practitioners should consider an intersectional lens that explores how social class, gender, race, ethnicity, and other social identities intersect and overlap.[22,23] For example, a young unmarried mother of lower economic status who belongs to a marginalized ethnic group is less likely to freely access FP/RH services and receive the same quality of care as an older, married woman of higher economic status belonging to the dominant ethnic group. The young unmarried mother may be further disadvantaged by the inability to pay fees or other health-related costs, lack of access to public or private transportation for accessing health services, more unequal power dynamics and less trust with health providers, and/or low health literacy for understanding and following through on health provider recommendations.

> "**Vulnerable populations** are groups and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability."[21]

Higher levels of vulnerability and exposure to high-risk conditions manifest across the five domains of SDOH in myriad ways. The following examples of SDOH that influence FP/RH are organized according to domain. This is not a comprehensive list as specific SDOH must be identified according to context; however, these examples can be considered in SBC programming addressing FP/RH.

Examples of Social Determinants of Health Influencing FP/RH

Economic Stability

- Limited access to financial resources to cover cost of FP/RH accessing information, services, and products
- Limited access to employment opportunities that provide sick leave and other benefits that facilitate access to self-care activities and healthcare information, services, and products

Education Access and Quality

- Inequitable access to education based on social class, gender, race, ethnicity, disability, or other social identities
- Unsafe or dangerous conditions within schools and universities or surrounding areas
- Lack of safe and/or functional restrooms in schools and universities for girls and women
- Lack of comprehensive sexuality education in schools
- Poor quality of language and literacy instruction in schools and linkages to health literacy

Health Care Access and Quality

- Lack of existence or access to universal health coverage
- Limited access to affordable, quality health services (e.g., comprehensive health insurance)
- Unsafe or dangerous conditions within health facilities or surrounding areas
- Low quality of counseling on all FP methods from health providers
- Limited availability of all FP methods at health facilities and pharmacies
- Limited health literacy around biological processes (e.g., fertility, reproduction) and other FP/RH information (e.g., birth spacing, modern methods)
- Limited outreach to and engagement of older people of reproductive age (35 years or older) in FP/RH information and services
- Stigma and discrimination against adolescents and youth, racial and ethnic minorities, and sexual and gender minorities in health facilities offering FP/RH information, services, and products
- Limited engagement of men and boys in FP/RH services and health promotion activities

Neighborhood and Built Environment

- Unsafe or dangerous conditions within and between neighborhoods and surrounding areas
- High prevalence of different types of violence (e.g., violent crime, violence against women, intimate partner violence, violence against children)
- Limited availability and access to health facilities and services
- Limited access to public transportation for accessing FP/RH and other health services
- Limited availability and access to water and basic sanitation services for maintaining hygienic conditions and disposing of human waste or sewage
- Limited access to telecommunications and technology for accessing information, services, and products

Social and Community Context

- Unsafe or dangerous conditions within neighborhoods and surrounding areas
- Absence of laws or failure to enforce laws against gender-based violence and violence against children
- Lack of gender-equitable norms and behaviors as well as inadequate gender-based violence prevention and response support
- Limited social support for comprehensive sexuality education
- Limited parental, guardian, and/or peer support for FP method uptake and use
- Stigma and discrimination against adolescents and youth seeking FP/RH information, services, and products
- Limited or inequitable engagement of men and boys in FP/RH communication, negotiation, and decision-making
- Limited opportunity to participate in decision-making processes affecting health and well-being (e.g., health policy development, local governance structure)
- Lack of a culture of collective action to affect structural and social change

Generating more equitable conditions for all means ensuring that everyone has the same access to FP/RH information, services, and products and "that they are able to make decisions about their fertility and their use of contraception and act on those decisions," free from discrimination, coercion, or violence.[12] By addressing poverty and other priorities affecting the most impacted individuals and groups across the five domains of SDOH, SBC programs can more directly contribute to achieving health equity.

Addressing Social Determinants of Health and Health Equity in SBC Programming

Designing effective SBC programming is already complex and integrating SDOH while leveraging existing SBC approaches and tools requires additional work. Many approaches and tools—such as the SBC Flowchart, C-Modules, Integrated SBC Framework, P Process, and THINK | BIG (Behavioral Integration Guidance)—already contemplate SDOH influencing behaviors and outcomes in FP/RH and other health and development areas. However, while recognizing the influence of SDOH on health behaviors and outcomes, these resources often stop short of providing practical guidance on identifying, prioritizing, and addressing SDOH in SBC programming. This section offers key considerations and illustrative actions that serve as a starting point for practitioners to design multifaceted interventions or redesign components of existing interventions that intentionally and consistently integrate SDOH and advance health equity.

Overarching Considerations

Practitioners can be much more intentional and consistent in designing SBC interventions that are multi-level and multi-sectoral in scope. The list that follows highlights overarching considerations for incorporating SDOH into the design, implementation, and monitoring and evaluation of SBC programming.

During the design phase:

- In partnership with the most impacted individuals and groups, identify and prioritize the SDOH domains that appear to be the root causes of challenges relating to the program's target groups, behaviors, and outcomes. Strategically select the social determinants that most directly impact the behavioral determinants (e.g., environmental, knowledge and skills, ideational), behaviors, and outcomes related to the most impacted individuals and groups (see *Identifying and Prioritizing the Most Impacted Individuals and Groups and Identifying and Analyzing Social Determinants of Health and Health Inequities* in this document).
- Carefully consider existing initiatives and programs and diverse partners and stakeholders across sectors—including government institutions, CSOs, affected populations, private sector entities, media organizations, implementing partners, and funding organizations—to engage in partnerships and coalitions for addressing relevant social determinants (see *Developing Essential Partnerships and Coalitions* in this document).

During the implementation phase:

- Within a single SBC intervention, combine and build upon strategies and activities across as many SDOH domains as feasible without sacrificing the overall quality and depth. Several factors will determine feasibility, including time, budget, scope, and staffing (see *Selecting, Designing, and Implementing Appropriate Strategies* in this document).
- Strategically leverage existing initiatives and programs (e.g., local accountability platforms, participatory budgeting processes) and carefully engage with existing and new partnerships and coalitions across sectors to broaden the SBC program's reach and impact (see *Developing Essential Partnerships and Coalitions* in this document).

During the monitoring and evaluation process:

- Measure how different social determinants influence priority groups, behavioral determinants, behaviors, and outcomes, as well as how different social determinants overlap and interact with one another to influence the same. In this way, measurement of social and behavioral elements can be linked in SBC programs (see *Measuring Social Determinants of Health and Health Equity* in this document).
- Monitor activities for the impact of social determinants across relevant SDOH domains throughout the SBC program cycle, to improve outcomes at higher levels of the socio-ecological model. Monitoring should apply innovative quantitative and qualitative methods as relevant, including

complexity-aware approaches to monitor intended and unintended consequences (see *Measuring Social Determinants of Health and Health Equity* in this document).

- Include SDOH indicators in evaluation and impact studies of SBC programs to ensure that the effects of, and interactions among, all social-ecological levels are assessed for changes and impact (see *Measuring Social Determinants of Health and Health Equity* in this document).

Unpacking Poverty in SBC Strategy Design Workshops

Participants in design workshops often mention poverty as a root cause of many behavioral determinants (e.g., environmental, knowledge and skills, ideational), behaviors, and outcomes. Facilitators should work with participants to unpack what "poverty" means and its role in influencing and conditioning relevant behavioral determinants, behaviors, and outcomes. Critical questions to ask include the following:

- What does "living in poverty" mean in this environment?
- What types of vulnerabilities and exposures to high-risk conditions are experienced by those living in poverty? Why?
- How do experiences of poverty vary according to different social identities (e.g., social class, gender, race, ethnicity, disability, education, income, wealth, occupation, religion)? How do they intersect and overlap?
- What other service delivery, education, or livelihood components can you add or link to the program to ensure that poverty-related issues of access, equality, equity, and inclusion are adequately addressed?

Additional Considerations

Program designers and implementers can also take action to incorporate SDOH into SBC programming by considering the following recommendations. These recommendations will continue to evolve as practitioners and researchers learn more about applying SDOH to SBC programming.

Identifying and Prioritizing the Most Impacted Individuals and Groups

No matter the health or development issue, the most impacted individuals and groups in a given environment often consist of those who are unserved, underserved, and/or inadequately served due to bias, stigma, and discrimination. Examples of such individuals and groups include people living in poverty in remote rural areas or informal urban settlements, adolescents aged 10–19, adults aged 50 or more years, migrant populations, racial and ethnic minorities, sexual and gender minorities, people with disabilities, sex workers, and/or people who use drugs.[24] In the case of FP/RH, the most impacted individuals and groups will be those with little to no access to FP/RH information, services, and products and little to no ability to make decisions voluntarily and knowingly about their fertility and method use and act on those decisions free from discrimination, coercion, or violence. To improve health equity in FP/RH, SBC programs need to assess the level and quality of outreach and engagement with FP/RH information, services, and products and the ability of diverse individuals and groups to make informed decisions and act on them. As part of this assessment, practitioners can do the following:

- Recognize the most impacted individuals and groups as experts and voices of lived experience.
- Consult with diverse partners and stakeholders—especially community members—to identify and prioritize the most impacted individuals and groups more comprehensively. Factor in sufficient time to identify and meaningfully engage with the most impacted groups and work with and through trusted intermediaries when possible.
- Use findings from other analyses (e.g., situation analysis, audience analysis) to develop an initial list of priority groups for further verification.
- Classify the priority groups according to level and quality of outreach and engagement—that is, unserved, underserved, or inadequately served (see the *Context-Defined Outreach and Engagement* box).
- Assess the unique concerns and needs of these priority groups across each of the SDOH domains to better understand the full spectrum of their lived experiences. Consider the degree to which different SDOH domains and specific social identities (e.g., social class, gender, race, ethnicity, income, wealth, education, disability) overlap and intersect to impact behavioral determinants, behaviors, and outcomes for these priority groups.
- Apply an intersectional lens to consider how social class, gender, race, ethnicity, disability, and other social identities intersect and overlap and, ultimately, influence how priority groups experience social determinants across all domains. For example, economic empowerment plays a role in improving women's autonomy, agency, status, and use of FP/RH information, services, and products.

Context-Defined Outreach and Engagement

SBC practitioners can utilize "The 3-Tier System"[25] to consider and contextualize the vulnerabilities and exposures to high-risk conditions that people and communities experience across the environment in which the SBC intervention takes place. This classification system qualifies people and communities as being unserved, underserved, and/or inappropriately served by outreach and engagement efforts and can be applied to health and other areas as relevant.

Unserved refers to those who are not reached at all with outreach and engagement (e.g., FP/RH information, services, products). It can also apply to those who are emerging and not yet visible or who appear in very small numbers.

Underserved refers to those who are growing in visibility and number and minimally reached with outreach and engagement, yet still need them to be tailored to their specific needs and priorities.

Inadequately Served refers to those who may be highly visible or even overrepresented in number, yet still need improvements in outreach and engagement to address ongoing barriers and challenges (e.g., bias, stigma, discrimination). Overrepresentation demonstrates a need for enhanced support to these people and communities.

USEFUL RESOURCES

Identifying and Prioritizing the Most Impacted Individuals and Groups

Creating Equitable Access to High-Quality Family Planning Information and Services: A Strategic Planning Guide

What Does it Mean to Leave No One Behind? A UNDP Discussion Paper and Framework for Implementation

10 Best Resources on…Intersectionality with an Emphasis on Low- and Middle-Income Countries

Intersectionality, Race and Decolonisation

How to Conduct a Root Cause Analysis

How to Conduct a Situation Analysis

How to Do an Audience Analysis

How to Do Audience Segmentation

Advanced Audience Segmentation for Social and Behavior Change

Developing Essential Partnerships and Coalitions

Given that no single SBC program will be able to address all SDOH that shape and influence target behaviors and outcomes for priority groups, multi-sectoral partnerships and coalitions are needed. SBC programs are typically focused on a primary health or development outcome, so they may struggle to address SDOH that fall outside of their scope of work. Effective partnerships and coalitions bring together diverse partners and stakeholders who can help identify and address other social determinants that a single SBC program could not otherwise address. Strong collaboration and coordination with other efforts and initiatives should be continually fostered to maximize efficiencies, reach, and impact. Some key considerations include the following:

- Engage funding organizations in discussions early and often about the need for multi-sectoral partnerships and coalitions and the appropriate level of funding to be effective.
- Invest early and often in engaging diverse partners and stakeholders across the SDOH domains for multi-sectoral perspectives and solutions throughout program design and implementation.
- Conduct a stakeholder analysis beyond the health sector and map existing programming in other relevant sectors to further contextualize the situation analysis. Strategically think through who should fill different roles—partners, allies, gatekeepers—to help broaden impact across socio-ecological levels influencing behavioral determinants, behaviors, and outcomes for the priority groups.
- Include individuals from priority groups in decision-making processes and engage priority groups across different types of lived experience in partnerships and coalitions.
- Develop key metrics for partnerships and coalitions to be able to monitor and track engagement, effectiveness, and accomplishments along the way.
- Include multi-sectoral partnership and coalition-building activities in budgeting and work planning each year to account for impact on implementation budget and timelines and ensure continuous engagement across all domains and socio-ecological levels throughout program implementation.
- Develop a shared sense of purpose, unifying message, and transparent structure that motivates diverse partners and stakeholders to champion their respective roles in multi-sectoral action and commit institutionally to health equity.
- Anticipate and plan for power dynamics and tensions in multi-sectoral partnerships and coalitions. Create a common language and transparent mechanisms for addressing and managing both in supportive ways. Leverage conflict to deepen relationships and encourage creative thinking.
- Embrace community members as key partners in problem solving and decision-making. Think about how best to support community leaders and community-based organizations in increasing access, equity, and inclusion of priority groups (see *Engaging Community Members from Start to Finish* in this document).

Partners, Allies, and Gatekeepers help maximize impact and share the effort to increase access, equity, and inclusion of priority groups across SDOH domains and improve their health and well-being.[26]

- **Partners** are individuals, groups, or organizations that collaborate with the program and provide direct support and resources. For example, the Ministry of Health collaborates with an SBC program that addresses provider bias as a barrier to adolescent-friendly FP/RH services in public health clinics.
- **Allies** are individuals, groups, or organizations whose own mission and objectives support the program's work. For example, the Ministry of Education may already be invested in supporting school enrollment and attendance for adolescent girls and a potential ally for an SBC program that promotes FP/RH outreach and engagement with adolescent girls and their support networks to prevent unintended pregnancy, a common barrier to school completion.
- **Gatekeepers** are individuals, groups, or organizations that limit or facilitate access to the buy-in, support, and resources needed for program implementation and/or successful achievement of program objectives. For example, the Ministry of Religious Affairs could hinder or help efforts to work with unmarried adolescent girls outside the home in an environment where their movement is restricted.

By engaging appropriate partners, allies, and gatekeepers across SDOH domains as soon as possible, practitioners can:

- Strengthen awareness of critical linkages and enhance advocacy for multi-sectoral solutions and action.
- Build multi-sectoral partnerships and coalitions capable of addressing and influencing social determinants at higher socio-ecological levels for broader and more sustainable impact.
- Mobilize buy-in, support, and resources to broaden the program scope and scale to address more SDOH domains whenever relevant and feasible.

Individuals, groups, or organizations who may *not* be allies can also influence program implementation and/or the achievement of program objectives, so outcomes may depend on how well practitioners identify non-allies and develop strategies to engage them in intentional ways that acknowledge real and perceived conflict. In some cases, engaging non-allies may neither be appropriate nor possible. Regardless, these considerations will help SBC practitioners anticipate and prepare for challenges and opportunities along the way.

USEFUL RESOURCES

Developing Essential Partnerships and Coalitions

Coalition Building Guide

Coalition Building Primer[27]

Health Service Planning and Policy-Making: A Toolkit for Nurses and Midwives—Module 2: Stakeholder Analysis and Networks

Multisectoral Integration of Social and Behavior Change Programming

A Practitioner's Guide for Advancing Health Equity: Developing Partnerships and Coalitions to Advance Health Equity

Multisectoral Integration of SBC Programming: A High-Level Exploration of Integrating Family Planning with Other Development Sectors

Identifying and Analyzing Social Determinants of Health and Health Inequities

SBC practitioners can use the best available data to analyze and deepen their understanding of SDOH and health inequities in the target environment. They should consider the following as they move further into program design:

- Integrate the SDOH domains into the program design process (e.g., literature review, situation analysis) to develop a comprehensive understanding of diverse social determinants influencing the behavioral determinants, behaviors, and outcomes among priority groups in a given environment.
- Use the best available data (e.g., datasets, journal articles, grey literature) to deepen understanding of the relationship between social identities (e.g., social class, gender, race, ethnicity, disability), the poorest health outcomes, and the most critical social determinants.
- Verify previous assessments of priority groups and behavioral determinants, behaviors and outcomes and clarify linkages with relevant SDOH domains and the most critical social determinants. Ensure that the SBC program aims to reach the most impacted individuals and groups and increase access, equity, and inclusion.
- Facilitate participatory design workshops that foster dialogue about SDOH and health equity and promote creative thinking around multi-sectoral solutions and actions. Dedicate time to developing a common language and examining real and perceived barriers and opportunities.

USEFUL RESOURCES

Identifying and Analyzing Social Determinants of Health and Health Inequities

Leaving No One Behind: Equality and Non-Discrimination at the Heart of Sustainable Development: A Shared United Nations System Framework for Action

A Practitioner's Guide for Advancing Health Equity: Identifying and Understanding Health Inequities

Wealth Index

Sustainable Development Goals (SDGs) Index

Intersecting Inequalities: Gender Equality Index

What is a Behavior Profile?

Engaging Community Members from Start to Finish

SBC practitioners are already well-versed in community engagement given the nature of their work. However, successfully tackling social determinants requires increasing community ownership of SBC programming and its results to achieve health equity and improve health and well-being across SDOH domains. In addition to best practices for community engagement, SBC practitioners can consider the following:

- Develop a common language for discussing and measuring changes to SDOH and health equity in locally-relevant ways and transparent mechanisms for increasing community ownership of SBC programming and results over time.
- Acknowledge and promote the expertise of community members in identifying and prioritizing the most impacted individuals and groups and understanding how they experience and are impacted by social determinants.
- Leverage existing groups and organizations at different levels (e.g., local, district, regional) that are already engaged with community members in understanding and addressing SDOH across different domains. This may require supplying resources, training, or information to support implementation of relevant activities.
- Engage and strengthen the capacity of various community leaders and groups to collectively plan, implement, and monitor activities that address SDOH.
- Leverage and strengthen local accountability platforms and participatory budgeting initiatives at different levels (e.g., local, district,

regional) to advance community participation and ownership. Include community members in evaluating the impact of these existing mechanisms on longer-term structural change.[28]

- Identify, amplify, and support informal and formal opportunities and mechanisms for communities to hold government institutions and private sector entities accountable for addressing social determinants and advancing health equity.
- Develop materials and activities with intended audiences in a participatory manner from the beginning, building on the insights and creativity of the most impacted individuals and groups to address social determinants in their environment.
- Engage community members in conducting monitoring and evaluation activities to strengthen local understanding of the relationship between social identities (e.g., social class, gender, race, ethnicity, disability), the poorest health outcomes, and the most critical social determinants.
- Share findings with diverse partners and stakeholders during relevant meetings and events (e.g., partnership and coalition meetings, press conferences) in a way that enhances their ability to hold government institutions, private sector entities, community organizations, and other groups accountable for their actions.

USEFUL RESOURCES

Engaging Community Members from Start to Finish

A Practitioner's Guide for Advancing Health Equity: Meaningful Community Engagement for Health and Equity

Participation as a Driver of Health Equity

Participation Guide: Involving Those Directly Affected in Health and Development Communication Program

How to Mobilize Communities for Health and Social Change: A Field Guide

Selecting, Designing, and Implementing Appropriate Strategies and Activities

SBC practitioners can leverage existing best practices for developing strategies and activities and incorporate SDOH according to time, budget, scope, and staffing. The following key considerations can help SBC practitioners thoughtfully integrate SDOH into program strategies and activities:

- Identify the level of scale-up early on to inform the selection and engagement of diverse partners and stakeholders in partnerships and coalition-building.[29]
- Use findings from completed analyses and evaluations to inform the development of relevant approaches and strategies for improving access, equity, and inclusion for the priority groups.
- Explore which strategies and activities lend themselves to addressing the selected social determinants influencing behavioral determinants, behaviors, and outcomes.
- Consult with diverse partners and stakeholders about cultural appropriateness and cultural relevance.
- Strategically sequence program strategies and activities in mutually reinforcing ways and thoughtfully consider the frequency and intensity needed to effect sustainable change across SDOH domains and at higher levels of the socio-ecological model.
- Embrace adaptive project management to evaluate and adjust program strategies and activities as relevant and feasible to directly influence the most critical social determinants.

USEFUL RESOURCES

Selecting, Designing, and Implementing Appropriate Strategies

Factors Influencing the Scale-up of Public Health Interventions in Low- and Middle-Income Countries: A Qualitative Systematic Literature Review

Scaling Up Projects and Initiatives for Better Health: From Concepts to Practice

Adaptive Management: What it Looks Like in Three International Development Projects

Measuring Social Determinants of Health and Health Equity

Any solid monitoring and evaluation (M&E) plan for an SBC program will includes relevant social identities (e.g., social class, gender, race, ethnicity, income, wealth, education, disability) and indicators for behavioral determinants and behaviors (e.g., knowledge, attitudes, beliefs, norms, perceptions). It will also include data collection methods, frequency, timing, and sources. Importantly, the M&E plan should detail how data will be used to adjust and optimize program strategies and activities as part of adaptive project management. Program staff will need to supplement the current M&E plan with parallel information on SDOH and health equity. The following are key considerations for ensuring that SDOH and health equity are properly measured, monitored, and evaluated:

- Develop a shared learning agenda for addressing SDOH and health equity in collaboration with diverse partners and stakeholders across multiple sectors.
- Use a combination of quantitative and qualitative methods, including complexity-aware methods, to provide a more comprehensive understanding of how different social determinants influence target groups, behavioral determinants, behaviors, and outcomes, as well as how different social determinants overlap and interact with one another to influence the same.*
- Allocate budget and staff accordingly for the expanded M&E activities to capture changes and impact of social determinants across SDOH domains.
- Monitor and track changes in laws and policies that impact SDOH. Conduct media content analysis monitoring and interview key informants at different socio-ecological levels to learn about laws and policies and their impact on selected social determinants. Examples of changes in laws and policies include expanded social assistance programs, improved access to educational opportunities, or increased access to affordable health care.
- Implement different types of evaluations (e.g., process, impact, outcome) to generate and share lessons learned on applying SDOH to SBC programming and its impact on behavioral determinants, behaviors, and outcomes among priority groups. Leverage evaluations to test best, promising, and emerging practices for addressing and measuring SDOH and health equity.

**Quantitative methods should treat SDOH as primary and secondary variables, not just as background variables or "confounders." Qualitative methods, including complexity-aware approaches like Outcome Harvesting and Most Significant Change, supplement quantitative indicators and help assess changes in SDOH and health equity. They can also illuminate the degree of influence of SDOH on behavioral determinants, behaviors, and outcomes among priority groups.*

- Consider including SDOH variables in bivariate and multivariate analyses (e.g., wealth, food security, educational attainment, neighborhood aspects, inequality measures regarding access to information, services, education, and basic necessities), assessing the relative contributions of structural-, community-, and individual-level factors on the outcomes of interest, and examining the SDOH that are significantly associated with behavioral determinants, behaviors, and outcomes.
- Plan to disaggregate all results by key social determinants—such as gender or sex (e.g., gender of birthing parent, assigned sex of birthing parent), age (e.g., age of pregnant or birthing parent), economic status (e.g., wealth quintile, wealth decile), education (e.g., educational attainment), place of residence (e.g., census area), marginalization (e.g., stigma, discrimination, social exclusion), and geographic location (e.g., subnational region)—to assess the degree of inequality in intermediate and behavioral outcomes. This will help assess program reach and impact in the short-, medium-, and long-term in socially determined audience segments.
- Analyze and interpret program results with a focus on policy and programmatic implications and in a manner that can be readily understood by diverse audiences, including those who have low literacy skills.
- Consider holding data use workshops prior to broader dissemination meetings to clarify definitions of SDOH indicators. Provide opportunities for diverse partners and stakeholders to review and discuss findings in terms of access, equity, and inclusion and discuss how they might apply them to current or future SBC programming.

USEFUL RESOURCES

Measuring Social Determinants of Health and Health Equity

Discussion Paper on Equity for the HIP Partnership

Approach for Diagnosing Inequity in Family Planning Programs: Methodology and Replication Guide

Complexity-Aware Monitoring, Evaluation & Learning for Social and Behavior Change Interventions

How to Develop a Monitoring and Evaluation Plan

Illustrative Actions to Integrate the Social Determinants of Health into SBC Programming

The following table provides examples of strategies and activities for addressing SDOH impacting behavioral determinants, behaviors, and outcomes related to FP/RH and other health areas. The first column specifies the relevant SDOH domains from the Healthy People 2030 framework. The second and third columns provide examples of program components that can be feasibly implemented within the scope of your SBC program and those that may require multi-level, multi-sectoral partnerships or coalitions, respectively, for successful implementation.

SDOH Domain	Program components for implementation through SBC programs[†]	Program components for implementation with government counterparts and other partners
Economic Stability	• Link program participants to social assistance programs that provide income and in-kind support to individuals and households living in poverty • Ensure more accountability of community and national levels to address community structural needs (involving them in budget cycle discussions) through community engagement programming	• Provide unconditional or conditional cash transfers • Mobilize internal and external financial resources to support the provision of health services and products, social support services, and safety nets
Education Access and Quality	• Promote supportive gender and social norms for equal access to education • Advocate and promote non-formal education and training opportunities for adolescents and young adults • Train community members on how to advocate for improvements in school infrastructure with government institutions and private sector entities	• Improve access to formal education and training opportunities for girls and boys across their lives, including secondary school and trade schools • Improve the safety and resilience of school infrastructure (e.g., restroom privacy and hygiene) • Create and enhance safe learning environment through faculty and staff training and inclusive policies and practices

[†] *For example, advocacy, community engagement, and social mobilization.*

SDOH Domain	Program components for implementation through SBC programs†	Program components for implementation with government counterparts and other partners
Neighborhood and Built Environment	• Identify planning priorities and needs to prevent and respond to gender-based violence in private and public spaces • Monitor and evaluate efforts and initiatives regarding disability-inclusive development to improve access in and around health facilities • Facilitate discovery workshops with diverse community members to understand how they physically navigate their neighborhoods and other spaces in accessing FP/RH information, services, and products	• Mobilize private sector investment in advancing sustainable planning and transportation • Foster public-private partnerships around improved the safety and resilience of physical spaces • Establish a local transportation mechanism for underserved communities to increase reliable access to health facilities (e.g., disability-inclusive public transportation)
Health Care Access and Quality	• Support improved cultural and gender competence among FP/RH providers, information, and services • Facilitate workshops on partnership defined quality with health facility staff and providers and community members for increased ownership and accountability • Support local resource mobilization to fund community-based health initiatives and source essential FP/RH products • Strengthen the capacity of health facility staff and providers to assess health care delivery for social inclusion and exclusion (e.g., disability inclusion)	• Improve health facility infrastructure and availability of medical and non-medical supplies (e.g., essential FP/RH products) in areas with the lowest access and/or quality • Update licensure and continuing education requirements for health providers to include gender and cultural competence and cultural humility in health care[30,31,32] • Establish community-based referral systems and linkages with social assistance and other support and resources • Establish a loss to follow-up tracking system to accurately assess the reach of services within a catchment area

SDOH Domain	Program components for implementation through SBC programs†	Program components for implementation with government counterparts and other partners
Social and Community Context	• Support or establish community-based incentives and promote social and gender norms that encourage equal access to FP/RH information, services, and products and adoption of FP/RH behaviors • Promote dialogue about SDOH and health equity among existing community-based organizations and other priority groups • Support capacity strengthening of existing systems and processes among local government institutions, non-governmental organizations, and community-based organizations • Support community-based organizations and other mechanisms for linking priority groups (e.g., adolescent women, people with disabilities) to social assistance and other support and resources (e.g., community savings bank, mutual aid) • Leverage partnerships and coalitions to connect local, district, regional, national, and international initiatives (e.g., climate change resilience and adaptation, global health security agenda)	• Advocate for more accountability of local, district, regional, and national authorities to address community priorities and needs around structural and social issues and engage community members in key decision-making processes (e.g., budgeting) • Establish regular accountability and advocacy meetings with local, district, regional, and national authorities • Implement participatory budgeting initiatives that address community priorities and needs

Conclusion

As noted in a recent Lancet paper, FP/RH programs and services must consider and address the priorities and needs of individuals and groups most impacted by vulnerabilities and exposures to high-risk conditions to advance health equity, eliminate disparities, and improve health and well-being for all.[24] In FP/RH and other health areas, SBC practitioners can play a greater role in ensuring that everyone, including vulnerable populations, has the same access to health information, services, and products and that they can make decisions and act on those decisions free from discrimination, coercion, or violence. This thinking tool provides SBC practitioners with key considerations and illustrative actions for identifying, prioritizing, and addressing SDOH in SBC programming in order to promote health equity. Yet, it is only a starting point, given that the SBC field is in the early stages of applying SDOH more intentionally. Discussion and documentation of how this work is being done, with what results, and the implications for improved health equity will be vital as the SBC field seeks to bring these efforts to scale (*see Appendix 1*). As SBC practitioners around the world strive to advance structural and social change, multi-sectoral coordination and collaboration remain as important as ever as the field builds more evidence around what works, helping them to collectively expand the "S" in SBC programming.

Appendices

Appendix 1: Case Studies

The following case studies provide examples of FP/RH and other health programming that applied SBC approaches to account for and influence SDOH at different levels of the socio-ecological model.

CASE STUDY

Go Girls!, Botswana, Malawi, Mozambique (2007–2011)

The PEPFAR-funded USAID Gender Initiative on Girls' Vulnerability to HIV (Go Girls! Initiative), a 3.5-year project managed by CCP, was implemented in four communities in the Thyolo district of Malawi, four communities in the Francistown district of Botswana, and eight communities in Mozambique (four in Zambezia Province and four in Nampula Province).

Objective: Reduce HIV transmission and improve sexual and reproductive health among adolescent girls in sub-Saharan Africa, in part by shifting the focus from girls' individual risk-taking to contextual factors that render girls vulnerable.

Social Determinant of Health Focus: Economic Stability, Education Access and Quality, Neighborhood and Built Environment, Social and Community Context

Strategies: The Go Girls! interventions span the socio-ecological model by combining traditional SBC approaches with social determinant interventions:

SBC Approach:

- **Community level:** community mobilization
- **Family level:** adult-child communication
- **Individual level:** community-based life skills; school-based life skills
- A reality radio program designed to increase legal literacy as well as community and adult support for girls

Social Determinant Approach:

- **Structural level:** Economic strengthening for girls and their families; school personnel training (to make schools safer); and cross-sectoral fora to engage community leadership

Target Audience: Adolescent girls and the adults responsible for their safety and well-being in the implementation districts.

Results: Compared with adolescent respondents at baseline, as well as at endline in the non-intervention schools, girls in the intervention schools were statistically and significantly more likely to report that they found talking with teachers about HIV/AIDS was "easy" or "very easy"; incidence of teachers offering students favors in exchange for sex decreased over the past year; and they felt safe or very safe in school. Girls whose parents, whether their mother or father or both, participated in the adult-child communication program reported higher-quality relationships with their caregivers; this has been shown to be protective in relation to HIV outcomes. Moreover, legal literacy was higher among participants compared with non-participants. Finally, community mobilization activities achieved profound changes in communities regarding a collective response to the vulnerability of girls and young women to HIV and other health risks, such as violence. Together, these findings demonstrate that interventions addressing the structural and social environment can have important effects on the well-being of adolescent girls.

Materials and Resources: Go Girls! Campaign Kit and Go Girls Archives

CASE STUDY

Nutrition and Hygiene Project, Mali (2013–2019)[33]

The USAID-funded Nutrition and Hygiene Project (USAID/PNH), managed by Save the Children with core partner SNV, operated for six years to improve the nutritional status of pregnant and lactating women and children under two in six health districts of Sikasso Region, Mali.

Objective: Increase the adoption of optimal behaviors to support nutrition, health, hygiene, and sanitation; increase the production and accessibility of nutrient-rich foods; and improve the delivery of nutrition services to address acute malnutrition.

Social Determinant of Health Focus: Health Care Access and Quality, Neighborhood and Built Environment

Strategies: The project designed an integrated approach to increase nutrition behaviors using locally produced foods while simultaneously improving the cleanliness of the environment to prevent disease transmission and fortifying links between community and local health care systems coupled with farmer field schools.

SBC Approach:

Community-focused SBC and social mobilization activities were used to improve community-based management of acute malnutrition and encourage better interpersonal communication between health workers and caregivers to support and promote the adoption of recommended behaviors. For example, village SBC assistants engaged community leaders and actors in understanding the consequences of poor nutrition on women's health and the future health and well-being of children. Leveraging existing community structures, each target village established a village coordination committee to direct and coordinate nutrition and wash, sanitation, and hygiene (WASH) activities supported by the project.

Social Determinant Approach:

The project also worked closely with two local agriculture organizations to introduce locally available nutrient-rich products and new techniques to safely store foods longer, improving availability during the lean season. Notably, the project fostered a robust working relationship between community partners and municipal governments and saw approaches adopted or adapted by Mali's government and other NGOs.

Target Audience: Over six years, the project reached over 10,000 pregnant and lactating women and over 50,000 children under two.

Results: The final evaluation (June 2019) indicated strong results, including a decline in the percentage of underweight (by 38%) and stunted children (by 11%), and an increase in access to improved sanitation (by 104%), water sources (by 85%), and positive nutrition behaviors (by 79% for exclusive breastfeeding and by 43% for a minimum acceptable diet).

Materials and Resources: Learning Brief: Strengthening Malnutrition Services at Community Health Centers in Sikasso, Mali, Learning Brief: Dynamic Community Approaches Promote Health in Sikasso, Mali, and USAID/Nutrition and Hygiene Project Final Report

CASE STUDY

NOURISH, Cambodia (2014–2020)

In partnership with the Royal Government of Cambodia, the six-year USAID and Feed the Future-funded NOURISH project (2014–2020), led by Save the Children, aimed to improve the nutritional status of Cambodian women and children in three provinces during the first 1,000 days of life.

Objective: Accelerate stunting reduction by focusing directly on the causal factors of chronic malnutrition specific to Cambodia: poverty, lack of access to quality food and nutrition services, unsanitary environments, and social norms and practices that work against optimal child growth and development.

Social Determinant of Health Focus: Economic Stability, Health Care Access and Quality, Neighborhood and Built Environment, Social and Community Context

Strategies: To create sustained demand for nutrition, WASH, and agricultural practices, services, and products, NOURISH applied a branded SBC campaign linked with community-led total sanitation and social protection mechanisms like conditional cash transfers as well as private sector engagement to address access to agriculture and WASH services and products.

SBC Approach:

The project's multi-faceted SBC campaign "Grow Together" was underpinning all aspects of the NOURISH program. Based on community-based formative research, the campaign integrated sectoral activities with a focus on 13 prioritized behaviors (across health, WASH, and agriculture) to stimulate actions for children to grow and reach their full potential of health and well-being. The campaign reached 98% of "first 1,000 days of life" caregivers through mass media, interpersonal communication with trusted agents of change, and community engagement activities (notably through community organized village fairs), supported with over 65 print materials. Grow Together connected rural families, health workers, community volunteers, leaders, and local businesses through the core creative concept: **that child growth is a key to both family happiness and community prosperity, only achievable when everyone grows together.**

Social Determinant Approach:

- Close collaboration at both national and sub-national levels with the Council for Agriculture and Rural Development, the Ministry of Health, the Ministry of Rural Development, and the Ministry of Agriculture, Forestry and Fisheries.

- NOURISH innovations such as small fish powder, the Child Length Mat, and multi-pronged approaches to strengthening capacity and sustaining WASH and agricultural enterprises (small and medium) helped increase access to nutrition, WASH, and agricultural products and achieve positive program results (see Business Service Centers).
- Conditional cash transfers and integrated vouchers to overcome financial barriers and increase access to services and support prioritization of key practices.

Target Audience: Rural women and children during the first 1,000 days of life—from conception until the child's second birthday—in 565 villages across Battambang, Pursat, and Siem Reap provinces.

Results: Significant changes in key health and agricultural behaviors resulted in a 19% reduction in stunting among children under five.

Materials and Resources: NOURISH in a Nutshell

Appendix 2: References

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