Regional SBCC Strategy to Support Nutrition Interventions in SADC: 2021-26

Program guidance to build regional capacity and improved efficiencies for evidence-based population-level nutrition interventions

Regional SBCC Strategy supported by SADC, UNICEF and GAIN: March 2021

gain Global Alliance for Improved Nutrition

SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
TOWARDS A COMMON FUTURE

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INDEX

ACRONYMS

ACPRP	Average-Cost-Per-Rating-Point
BCC	Behaviour Change Communication
CRIS	Communications Resource Information System
FGD	Focus Group Discussion
GAIN	Global Alliance for Improved Nutrition
GRPs	Gross Rating Points
IEC	Information Education and Communication
IPC	Interpersonal Communication
KPI	Key Performance Indicator
MAD	Minimum Acceptable Diet
MARPs	Most-At-Risk-Populations
MD&D	Music, Dance & Drama
M&E	Monitoring and Evaluation
MELA	Monitoring Evaluation Learning and Adaptation
MOE	Ministry of Education
MOH	Ministry of Health
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NVACs	National Vulnerability Assessment Committees
NSP	National Strategic Plan
INGO	International Non-Governmental Organization
PPP	Public Private Partnership
PSAs	Public Service Announcements
ROI	Return on Investment
QA	Quality Assurance
SADC	South African Development Community
SBCC	Social and Behaviour Change Communication
SCRM	Social Cause Related Marketing
SSI	Semi-Structured Interview
TOT	Training-of-Trainers
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
TOWARDS A COMMON FUTURE

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FOREWORD

By its very nature, a regional Social and Behaviour Change Communication (SBCC) strategy encompassing diverse country settings will be different to national SBCC strategies. The Southern African Development Community (SADC) is comprised of 16 member states separated by borders, development status, language and other sociocultural differences. The question arises: Can regional approaches provide improved synergies and efficiencies to deal with public health priorities such as malnutrition, which has seriously impacted on the region?

The regional approach acknowledges that there are health and development issues which cross borders and create enormous demands on already stretched health systems of member states dealing with many challenges and constraints. Given these challenges, it's important to combine and leverage resources through multisectoral, multilevel approaches, while working to achieve greater synergies to combat the health and challenges confronting the region. This regional SBCC Strategy for Infant and Young Child Feeding (YCF) does not replicate the many other national SBCC nutrition strategies developed for the African context. Rather, this strategy identifies opportunities to add-value to existing SBCC national approaches and provide greater efficiencies afforded through the sharing of best practice resources. Opportunities for adaptation and regional integration of SBCC methods, tools and activities are also provided. The SBCC strategy for IYCF provides a regional framework to articulate how nutrition stakeholders across the member states can work together more efficiently to optimize the delivery of best practice SBCC campaigns, as part of the broader raft of nutrition activities, while helping to build the evidence base for what works best in the region.

The social and behavioural determinants impacting on improved malnutrition outcomes are identified through a stakeholder needs assessment as are a range of behavioural theories to more efficiently drive the strategy. The regional SBCC strategy attempts to avoid adding further complexity to the technical processes involved with SBCC program planning, development, implementation and evaluation. A strategic planning model breaks down these complex activities into more manageable processes. A pragmatic, stepwise approach identifies what is currently being done with SBCC programs in member states and provides opportunities for continuous improvement of approaches, which can be applied across the region. This includes standardization of objectives, target groups, and the development of more empowering, emotionally charged messages to engage communities. Advice on how to best implement SBCC activities and disseminate resources across multiple communication platforms are also provided as are suggestions on layering and synergising of messages to address priority behaviours through mass media, community media and interpersonal communication approaches. A monitoring evaluation learning and adaptation (MELA) framework aims to build on the process of standardisation of best practice formative and evaluative approaches while learning and adapting MELA to the various country settings.

The regional strategy recommendations aim to reach out to SADC member state representative through a co-design philosophy to encourage greater sharing of nutrition program learnings and SBCC resources. An online web portal and repository of best practice tools and approaches is proposed, to include resources for easy adaptation to the various country settings. With time and the active contribution of member states, a broad range of best-practice resources, tools and approaches can be expanded upon to provide greater standardisation and easy adaptation to a range of country settings. I hereby, endorse this regional SBCC strategy and invite nutrition stakeholders from SADC member states to work more closely together to build greater political will, social mobilization and behavioural change to address malnutrition across the region.

EXECUTIVE SUMMARY

Malnutrition is a considerable health problem in the Southern African Development Community (SADC) Member States looking to build Social and Behaviour Change Communication (SBCC) technical capacity to stem the health burden. However, the challenges to operationalize Social and Behaviour Change Communication (SBCC) programs to improve infant and young child feeding (IYCF) are considerable. Challenges are compounded when the strategy aims for regional synergies across the 16 diverse Member States in SADC. However, with the challenges come a number of opportunities for development of best-practice approaches and continuous improvement building on the achievements of IYCF programs conducted to date in the region. To understand what works based on the evidence across the region, a needs assessment encompassing qualitative and quantitative approaches was undertaken to inform the SBCC strategy. Interviews were conducted with key informants from 6 member states. An online survey and media audit elicited responses from more than 60 participants across 11 SADC country settings.

Key elements, guiding principles and illustrative activities of this strategy, informed by the needs-assessment and literature review, are designed to operationalise evidence-based, best practice, SBCC nutrition programming approaches across the region. The strategy provides guidance to build SBCC technical and organizational capacity, participation, ownership and engagement by a broad number of regional partners. A Vision and Mission are proposed with an Action Plan for IYCF. Strategy architecture provides strong foundations for the 5-year term of the Strategy. Four Pillars underpin strategic actions for Strengthened SBCC Capacity—Improved Efficiencies, Supportive Regional Integration and Embracing Innovation. Improved outcomes are anticipated from increased sharing of best practice SBCC resources, the provision of consistent frameworks and indicators across the region, simplifying the process of adapting IYCF resources, and facilitating transformative changes to refresh and turbocharge the nutrition program. A 4-Stage SBCC Strategic Planning Cycle breaks down the complex range of activities into manageable Stages, with each Phase of the Cycle informing the next Stage of strategy evolution. A Stepwise Approach describes activities to Plan, Develop, Implement and Evaluate SBCC interventions and assist regional programmers to operationalise the SBCC campaigns more efficiently and share findings and resources with other member states. IYCF Program Objectives, Target Groups, Messages and Behaviours are outlined with a range of SBCC Illustrative activities. A Monitoring, Evaluation, Learning and Adaptation (MELA) Framework is proposed to build greater integration and continuous improvement of regional nutrition activities. SBCC Key Performance Indicators (KPIs) are proposed for integration across the SADC Member States to allow performance comparisons across the region, over the term of the strategy. To support regional integration, a number of useful SBCC tools, and resources will be uploaded onto a Regional IYCF Web Portal. An online Repository will also be developed and populated with best-practice IYCF materials from across the region to further aid in the adaptation of resources.

Working toward integration of priority IYCF nutrition programs to achieve greater efficiencies and impact-at-scale is an honourable and innovative approach for SADC, placing the agency at the forefront of regional transformative change, while dealing with a perennial health challenge. To be successful, the process going forward will require quality assurance checks to ensure that all partners are supportive of approaches. If coordinating mechanisms can be assured and successful partnerships developed, there are considerable opportunities for more sustainable SBCC programs for IYCF to achieve impact-at-scale among SADC Member States.

SBCC Strategy for Infant and Young Child Feeding in SADC Member States: 2021-26

1. BACKGROUND

The Southern African Development Community (SADC) is a regional economic development community comprising 16 Member States in the Southern African and Indian Ocean region. These are Angola, Botswana, Comoros, Democratic Republic of Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia and Zimbabwe. SADCs overall goal is to promote and achieve equitable and sustainable development through increased regional integration underpinned by an environment of peace, security and regional stability. SADC with support from European Union EDF 11 is tasked to develop a Social and Behavioural Change Communication (SBCC) Strategy for improved infant and young child feeding (IYCF). The Global Alliance for Improved Nutrition (GAIN) is jointly supporting SADC through the RISING initiative for the components of the strategy, including formative research with program stakeholders, message pre-testing to inform the design and an adaptable multi-media prototype campaign for IYCF.

1.1 Who is this Strategy for?

This SBCC strategy is designed for the reference of senior health officials and operational staff of SADC member states, involved with policy development, advocacy, design, implementation and evaluation of SBCC nutrition programs specifically related to IYCF. The strategy is also an important reference for private sector partners supporting nutrition interventions and products, media communication and market research companies, and international NGO partners seeking regional guidance for SBCC across the 16 member states.

1.2 Definitions

Social and Behaviour Change Communication for nutrition is defined as a set of interventions that systematically combines elements of interpersonal communication(IPC), social change and community mobilization activities, mass media, and advocacy to support individuals, families, communities, institutions, and countries in adopting and maintaining high-impact nutrition-specific and nutrition-sensitive behaviours or practices. Effective nutrition SBCC leverages enablers of behaviours and reduces barriers to adopting and maintaining behaviours over time[1]. SBCC uses key strategies of Advocacy—to raise resources and ensure political will, social leadership to achieve goals; Social Mobilization—to engender wider participation, coalition building, and community ownership and mobilization to address health problems; and Behaviour Change Communication—to raise awareness and achieve changes in knowledge, attitudes and behaviours among specific audiences[2]. SBCC approaches include the strategic application of evidence based, best practice, behaviour-centred communication interventions, disseminated across a variety of communication channels to raise awareness and support changes at population levels in nutrition program awareness, knowledge, attitudes, social norms, beliefs, perceptions, intentions and behaviours[3, 4, 5]

Malnutrition refers to deficiencies or excess of nutrients in a person's diet; this leads to either under nutrition or over nutrition leading to underweight - low weight-for-age; wasting – low weight-for-height; and stunting - low height-for-age. Underweight, wasting and stunting are related to micronutrient deficiencies or a lack of important vitamins and minerals, while malnutrition through can also result in overweight/obesity - too heavy for-height, resulting from energy intakes that exceed daily requirements[6, 7]. Malnutrition in underweight children includes hidden hunger – when children don't get enough essential vitamins and minerals as well as undernutrition – when children don't eat or absorb enough nutrients to grow[6].

An SBCC Strategy is defined as a focus of efforts and a specific course of strategic actions to achieve the SBCC program goals and objectives, defining where we are now to where we want to be. This includes stepwise guidance for the planning, development, implementation and evaluation of a SBCC campaigns and other interventions.

A *Prototype Campaign* is defined as an adaptable, 'Campaign-in-a-Box' of creative executions and management tools to provide guidance and support for multi-country implementation to be informed by the SBCC Strategy.

2.THE HEALTH PROBLEM

Despite good regional nutritional guidance to improve IYCF outcomes and a number of gains made in the past decade, acute malnutrition—stunting, wasting or overweight—remains stubbornly high across the region with rates of 2%-8.1%. With the added impact of COVID-19, acute malnutrition across the region is predicted to increase by 25% or more by 2021.[8]

2.1 The Behavioural Problem

Current communication approaches are not achieving the desired improvements in IYCF behavioural outcomes or providing compelling reasons for participants to engage in the program. Best practice approaches, Innovations and greater integration of efforts in the resource constrained settings is required to transform the IYCF program across the region.

3. SITUATIONAL ANALYSIS

A range of key documents and supporting literature was reviewed for the regional strategy design including donor flagship reports, other academic literature and secondary sources.

3.1 Global Nutrition Situation

Global estimates identify 47 million children under 5 being wasted in 2019 of which 14.3 million were severely wasted with 144 million being stunted[9]. Around 45% of deaths among children under 5 years of age are linked to undernutrition, which mostly occurs in low- and middle-income (LMICs) countries[2]. Child stunting and malnutrition is also associated with lower dietary diversity, with food insecurity and poor household food choices contributing to the lack in meeting children's nutrient requirements.[10,11] Additionally, malnutrition is seen to predominantly occur in regional hotspots where there is limited access to high protein foods, poor vegetation cover, and a proxy of rainfall or drought.[12] UNICEF reports that in nearly every part of the world, families face economic, political, market, social or cultural barriers to providing nutritious, safe, affordable and sustainable diets to young children[13,14,15]. Socioeconomic determinants in many countries play a significant role in food insecurity and diversity of food choices, which lead to childhood and maternal malnutrition[16].

3.2 Regional Situational Analysis

The SADC 16 Member States in the Southern African region are also seen as having a responsibility to support nutritional initiatives given the multi-layered influences that impact on food choices, with government policies, priorities, and assistance programs operating at an individual level, while sociocultural, community, environmental, agricultural, industry and market influences are also seen as impacting on healthier nutritional behaviours[17]. These challenges are exacerbated in humanitarian situations in the poorest and most fragile economies where access to nutritious food, clean drinking water, and good quality health services are limited, and the resources and capacities of caregivers are already stretched.

Young children and their caregivers in the region are seen to be increasingly exposed to foods of low nutritive value, including commercial complementary foods and processed foods high in added sugar, salt and saturated fats and trans fats, due to their low cost, ubiquity, and the ease of feeding to young children[3]. Thus, the developmental, economic, social, and health impacts of the burden of malnutrition are serious and likely to worsen for individuals, families, and broader communities in SADC[4].

Systematic reviews of nutrition intervention to reduce childhood stunting, emphasize the importance of a combination of interventions including nutrition education and counselling, growth monitoring and promotion, immunization, and water interventions[18, 19]. Reviewers have found that this combination of interventions in the East and Southern Africa (ESA) region between 2000 and 2019, have led to significant reductions in stunting among children under 5 from 45.6% to 32.7%.[20] However, one in three children (29 million) still remain stunted in their physical and cognitive development, while wide-spread deficiencies in vitamins and minerals further undermine their health and well-being during critical life-stages from birth to 5 years of age[16]. Problems begin with poor breastfeeding practices with only 56% of infants in the East and Southern Africa region (ESAR) being exclusively breastfed for the first 6 months with growth-faltering rapidly accelerating during the complementary feeding period, between 6 and 23 months as children rely more on food to meet their high nutritional needs[21]. UNICEF has found that only 13% of children in ESAR are getting what is considered a Minimum Acceptable Diet (MAD)[9]. While one in 5 children under 5 years of age globally are classified as not growing well, that figure is 2 in 5 children under 5 years in ESAR[16]. The findings confirm

that for the vast majority of children, the quality, quantity and frequency of complementary feeding is inadequate for optimal growth and development.

The reasons for poor infant and young child feeding (IYCF) practices are complex and varied but include problems with food availability, accessibility, acceptability, and utilization. Four major interconnected drivers of diet have been identified, beginning with food supply chains that in turn influence both external food environments and personal food environments, and finally caregivers' behaviour related to food procurement, preparation and child feeding.[22]

Given the challenges of a number of the drivers of malnutrition, it is recommended that SBCC for this project should predominantly focus on the last driver related to preparation and child feeding practices with the aim of influencing and positively motivating IYCF behaviours[23]. The literature also identifies that along with inadequate care and feeding practices, household food insecurity, unhealthy household environments and inadequate health services are all behaviour related problems[4]. What is evident is the need for more rigorous formative research to understand the optimal dietary patterns to tackle the challenges of maternal health, child development, infection risk, and non-communicable diseases[24].

In terms of identifying regional priorities, SADC 16-Member State profiles identify considerable variance in country development status[25], culture—72 language groups identified across the region —[26]differences in literacy, educational attainment[27], GDP income and growth factors[28]. Five SADC Member States are identified as upper middle-income countries including: Botswana, Mauritius, Namibia, Seychelles, South Africa, while another six are designated as lower-middle income countries including Angola, Eswatini, Lesotho, United Republic of Tanzania, Zambia and Zimbabwe. Five SADC Member States including Comoros, Democratic Republic of Congo, Madagascar, Malawi, Mozambique, are designated as low-income status[29].

The variance in development indicators for IYCF country risk profiles also confirms the considerable differences (>20% variance) in stunting prevalence between the lowest and highest income countries where children are not growing well[16]. Available SADC country data from 2011 onwards identifies stunting rates from 31%-53%. This includes high rates of stunted, wasted or overweight children (31%-34%) in Namibia, Zimbabwe and Eswatini (Swaziland), and very high stunting rates (38%-44%) occurring in South Africa, Botswana, Tanzania, Lesotho, Rwanda, Angola, Malawi, and Comoros; while the highest rates of stunting, wasting and overweight (47%-53%) occur in the SADC countries of Zambia, Mozambique and Madagascar[21].

GAIN reviews on access to complementary foods in a number of regional country settings have also identified considerable differences in dietary nutrient gaps among children 6-23 months and priority affordable complementary foods to meet dietary nutrient gaps. The dietary recommendations often differ by country settings such as: Mozambique (eggs), Zambia (dairy), South Africa (highly fortified maize porridge), Uganda (small fresh-water fish), Ethiopia (eggs) and Tanzania (poultry). The foods selected in each country meet at least one important nutrient gap and their promotion aligns with government priorities and local preferences[30]. Minimum Dietary Diversity (MDD) is another regional indicator demonstrating the considerable disparities in country capacity to meet the dietary needs of children. In the Eastern Southern African Region (ESAR), only 12% of Ethiopian children aged 6–23 months eat at least 5 of 8 food groups to achieve MDD, with other low MDD countries including Lesotho, Zambia and Burundi (17%-18%). Mid-range MDD regional countries (21%-28%) include Tanzania, Namibia, Lesotho, Malawi, Namibia, Uganda and Rwanda, while countries with greater dietary diversity (29%-48%) include Angola, Kenya, South Africa and Eswatini (Swaziland)[21].

The literature also points to a number of other behaviour related, institutional, technical capacity and cultural challenges[31], as well as identifying behaviours that can improve nutrition outcomes[32]. Behavioural factors for SBCC include the complex range of IYCF recommendations related to breastfeeding, complementary feeding, infant feeding in the context of HIV/AIDS, and feeding children with special needs[33]. Coupled with the scarcity of resources to incentivize women and their family members to actively engage in the SBCC programs, these impediments will require highly creative and innovative solutions to achieve the project aims and behavioural objectives within a regional strategy design.

3.3 Covid-19

Covid-19 is not the first, nor will it be the last pandemic threat to ravage Africa and other regions of the world. SADC member states have suffered and continue to battle with serious pandemic threats and country epidemics of HIV/AIDS, drug resistant TB and Malaria, which are all major contributors to nutrition related comorbidities. The evidence to date indicates that Covid-19 and other epidemics will also significantly hamper any nutrition gains made in the past decade through job and income loss to populations most-at-risk to malnutrition[34]. Challenges are exacerbated by the redirection of critical health and infrastructure resources from priority health areas such as NCD prevention and control, and already stretched health systems. Nutrition stakeholders in the Member States need to maintain strong advocacy to ensure political will and funds are maintained for the nutrition program. In cases of food insecurity, humanitarian aid and food supplementation may need to be stepped up, particularly in areas most impacted by Covid-19.

SBCC programming staff and nutritionists are advised to stay updated on information regarding the pandemic and other and predominant issues which may impact the program, from their National Vulnerability Assessment Committees (NVACs). The NVACs are a key source of information for emergency response and development programming by both governments and partners as well informing policies in the area of food and nutrition security. The NVACs also build on the region's vulnerability assessment and analysis system for SADC Member States[35].

3.4 Communications Environment

The 16 SADC Member States have a range of communication options commonly available to low -and middle-income countries. This includes national and private sector Television and Radio networks, National and Regional Print and Outdoor Media options, and varying degrees of access to Mobile Media and Social Media. Given the differences in country income status, it is not realistic in the context of a regional strategy to speculate on preferences and dissemination costs for main media channels of communication. Suffice to say, opportunities to optimize a multilevel communication platform will need to be explored in every regional Member State considering implementing population level SBCC campaigns to achieve behavioural impact.

What is apparent among a number of SADC jurisdictions are the relatively high costs of mass media placement and the subsequent challenges in achieving cost efficiencies with media plans across a range of platforms, relative to a number of other regions[36, 37] . Given this scenario, it is likely that not enough has been done from a policy perspective to ensure adequate free-to-air or bonus spots are provided for priority health campaigns, either with government controlled national media networks or private sector media providers that rely on their programming licenses from Government Ministries of Communications and Information. Opportunities arise from the rapidly evolving social media landscape, mobile SMS and expanding chat channels like WhatsApp, to offer new ways to reach target audiences across the region, at considerably lower costs. This is despite the fact that digital users in Africa also pay the most for mobile data, relative to average monthly incomes[38].

Important channel factors to consider at a regional level for mass media communication is how to achieve regional efficiencies to affect the lowest Average-Cost-Per-Rating-Point (ACPRP) for media plans, which is a measure of reach and frequency of campaign messages on TV and radio. In order to achieve optimal dissemination of messages, media plans with adequate Gross Rating Points (GRPs) will need to be developed, to achieve broad reach and adequate message frequency if significant cut-through and impact is anticipated with mass media campaigns[39]. Predictive programming models for media should be the aim of regional approaches with a number of media audience research agencies currently operating across the region to collect and disseminate media audience data. These include The Broadcast Research Council of South Africa (BRC)[40], GeoPoll[41] and Kantar Media[42].

Other communication channel opportunities popular in a number of countries include community music, dance and drama, commonly termed 'Edutainment' with UNICEF programming guidance identifying the need to select multiple communication channels to achieve desired coverage, quality, intensity, and scale, while strengthening delivery platforms and communication channels in national SBCC strategies and plans using tested, context-specific SBCC messages[43].

3.4 Systems Thinking

Systems science applied to public health initiatives for a regional SBCC strategy to address IYCF provides a way of addressing the complexity at the design, implementation, and evaluation stages of the program, to improve health at population levels[44, 45]. There are increasing calls for the application of systems thinking and multisectoral approaches to improve dietary behaviours[46, 47]. The approach emphasizes the need to aim for more cross-cutting outcomes by including multisectoral engagement from government, the religious sector, civil society, the private sector and development partners. Systems approaches also use causal loop diagrams to identify stakeholder perceptions of how successful interventions operate through the dynamics of collaboration, network formation, community awareness, human resources and innovation[48]. Major interconnected drivers of diet have been identified through the Innocenti Framework[21] which highlights how food supply chains influence both external food environments and personal food environments, and finally caregivers' behaviour related to food procurement, preparation and child feeding. Thus, systems approaches have merit with the broader SBCC framework to capture, evaluate, disseminate and adapt the dynamic elements of successful SADC nutrition SBCC interventions as well as identifying the aspects of the system that can be supported through SBCC approaches.

4. NEEDS ASSESSMENT METHOD

A requirement of the needs assessment was to develop a practical, pragmatic, formative research method across SADC Member States given the pandemic threat of Covid-19. Primary data sources involved a mixed methods approach using *Qualitative Research* - 17 key informant interviews; supported by *Quantitative Methods* – an Online Survey of 61 respondents from six SADC Member States.

4.1 Key Findings

A broad number of issues related to the SBCC strategy for IYCF were canvassed with stakeholders, and a comprehensive needs assessment report compiled (see SBCC Strategy Annexes). Summary findings of program challenges and opportunities derived from primary data sources are provided in following sections. The inclusion of stakeholder feedback on aspects of the strategy are also included in sections of the report to ensure responsiveness to Member State needs and wants. A summary of identified program challenges and opportunities follows, with other priorities identified from the primary and secondary data-sources incorporated in strategy recommendations.

4.2 SBCC Program Challenges

The needs assessment and literature review identified a number of SBCC program milestones and achievements, but also ongoing challenges and opportunities for continuous improvement of the strategy, and regional synergies. Program challenges included the additional demands on health systems and human resources from pandemic threats such as Covid-19, poor attitudes and beliefs toward IYCF behaviours by some program beneficiaries, additional challenges from the dual burden of undernutrition and rapidly emerging burden of overnutrition and overweight, and financial resource capacity to implement and evaluate the SBCC campaigns at-scale.

4.3 SBCC Program Opportunities

Opportunities for the SBCC strategy identified by member state nutrition stakeholders included improved detection, better meeting IYCF nutritional needs from locally sourced, inexpensive, nutrient dense foods, training and capacity building of front-line field staff and other stakeholders whho could be engaged into the process, the inclusion of men into SBCC activities given their role in supporting better IYCF behaviours, and effective policy development to support parent-friendly hospitals and workplaces.

5. SADC REGIONAL SBCC STRATEGY VISION

The following vision and mission for the Regional SBCC strategy draws on the overarching Vision and Mission of the SADC secretariat. The Vision is as follows:

VISION

A reputable, efficient and responsive enabler for Regional SBCC integration to achieve optimal nutritional status across the region

5.1 SADC Regional Strategy Mission

The strategy Mission aligns with previous guidance documents and flagship reports [21,22,30,31,32,35] as follows:

MISSION

Provide SBCC strategic program guidance and support to build regional capacity, integration and improved efficiencies for evidence-based, population-level nutrition interventions, policies and performance measures.

6. REGIONAL SBCC STRATEGY ARCHITECTURE

Four pillars are proposed to underpin the SBCC strategy (see Figure 1.):

1. Strengthened SBCC Capacity
2. Improved Efficiencies
3. Regional Integration
4. Embracing Innovation

Regional SBCC Strategy Foundations recommend that Behavioural Theories and Best Practice approaches will drive the strategy. Second, a practical 4-Stage, Processing Model is incorporated into strategic planning processes to support the Operationalising of SBCC campaigns. Third, fundamental changes to traditional roles are suggested through a 'Co-Design Philosophy' to enable a wider range of creative contributions and nutrition solutions across the region. It is believed that Co-design principals can increase engagement, build SBCC skills and confidence, and deepen collaboration across Member States attempting to resolve major regional health and development challenges.

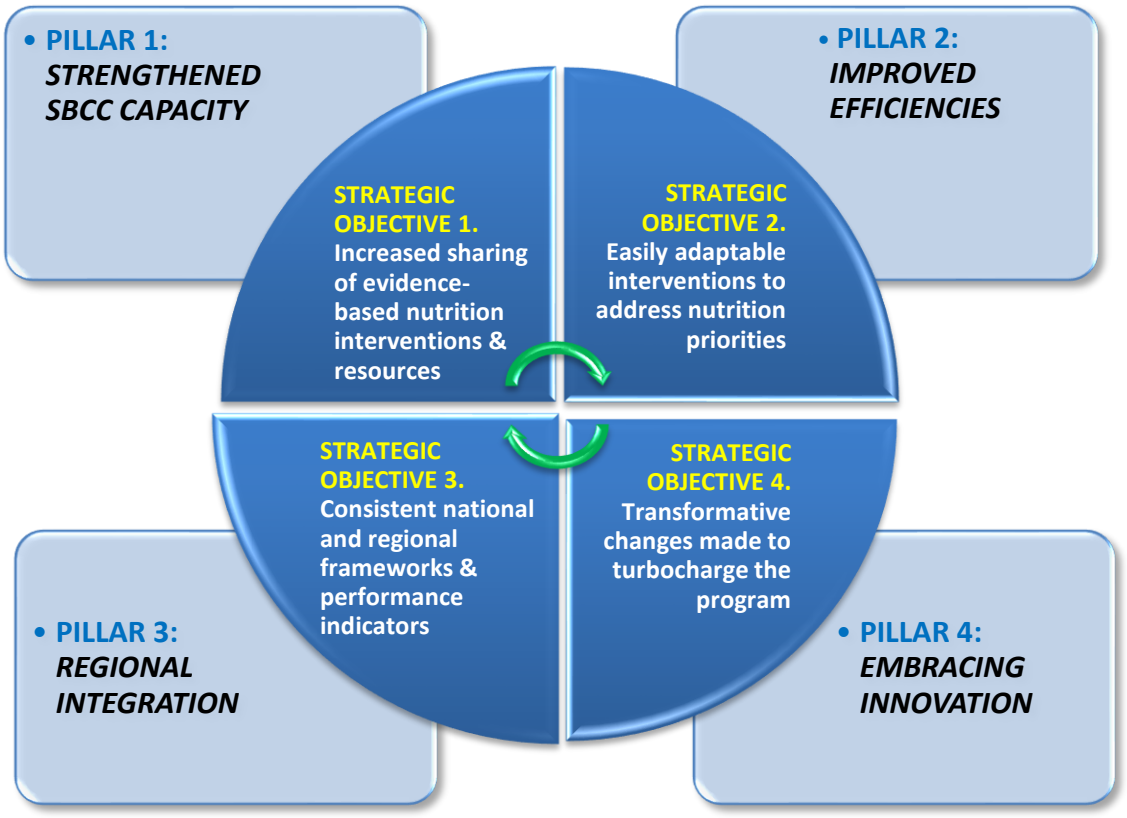

Figure 1. *Pillars Underpinning Strategic Objectives to Achieve Improved Outcomes*

6.1 Behavioural Theories to Drive the Strategy

No one behavioural theory can adequately address all of the social and behavioural determinants, as well as processing issues for optimal SBCC program consideration. Key elements of classical and modern theories are highlighted to provide a simpler narrative on how the theories can be operationalized.

- **Prioritizing the Problem:** Building risk perceptions[49] to set the program agenda and support the need to address malnutrition, while accepting that in vulnerable groups risk appraisal will be weighed against coping appraisals before making adaptive or maladaptive responses.
- **Building Capability:** Importance of modelling the desired behaviours[50], accounting for existing social norms[51], building capability[52], self-efficacy[53]—skills, confidence, and perceived behavioural control[54]—which are key drivers in influencing attitudes and intentions toward a behaviour.
- **Diffusion of Innovations:** Importance of identifying opinion leaders and key influencers for the diffusion of nutrition innovations and adoption of practices by other community members which may challenge existing social norms[55].
- **Strategic Long-Term Approaches:** Understanding that change takes time and people may go through a number of 'stages-of-change[56], before eventually changing previously entrenched behaviours.
- **Motivating and Mobilizing:** Acknowledging the importance of providing positive incentives to motivate[57] or 'nudge' participants[58] along the behaviour change continuum[59].

6.2 Four Stage - SBCC Strategic Planning Cycle

The Strategic SBCC Planning Cycle is a processing model which describes the flow of activities during each stage of the cycle (see Fig. 2)[60]. The model can assist in operationalising the complex range of activities to achieve best practice, evidence-based approaches. Completion of all 4-Stages of the Cycle or one SBCC Strategy Campaign Phase, may take from 9-12 months duration, given the broad number of activities required to adapt, implement, and evaluate evidence-based approaches.

Figure 2. *Four Stage SBCC Strategic Planning Cycle*

6.3 Stepwise Operational Approach

The following *Stepwise Operational Approach* provides practical, guiding principles for the Planning, Development, Implementation and Evaluation of IYCF SBCC activities to support and build on existing nutrition programs conducted in SADC Member States. The strategic approaches are underpinned by the Regional and National nutrition guidance including UNICEF/GAIN and national policy documents.

In order to effectively operationalize the SBCC strategy a greater understanding of the specific steps and activities involved in each of the four stages of the planning cycle will need to be developed by program managers, SBCC staff and support agencies. *10-Steps* are suggested to operational approaches and further assist in breaking down the complex array of SBCC activities into manageable and well-defined tasks. The stepwise approach also allows for partner review at the completion of each critical stage or milestone of the SBCC program, and as such, can encourage greater engagement and support from all partners. The *10-Step* approach for the strategy regional roll-out can also build capacity and provide skills-transfer for the many technical activities required to achieve best-practice approaches. The Steps are colour coded to aid in identifying where the activities sit within the 4-Stage SBCC Strategic Planning Cycle: Planning (Red), Development (Blue), Implementation (Green) and Evaluation (Orange) outlined in Table 1.

STEPWISE APPROACH TO PLANNING – DEVELOPMENT - IMPLEMENTATION AND EVALUATION	
Step 1.	**Define and Understand the Problem (e.g. KAP or precampaign study)**
Step 2.	**Identify SBCC Target Audiences**
Step 3.	**Set Campaign Behavioural Objectives**
Step 4.	**Develop a Workplan - Allocate Resources**
Step 5.	**Build Partnerships/Coordinating Mechanisms**
Step 6.	**Build SBCC Core Competencies**
Step 7.	**Develop Key Messages and Approaches**
Step 8.	**Select Communication and Distribution Channels**
Step 9.	**Implement the SBCC Campaign**
Step 10.	**Evaluate the Program – Advocate Findings for Next Campaign Phase**

Table 1. *Ten-Step approach to operationalise SBCC strategy campaigns*

Step 1. Define and Understand the Problem

This first step in SBCC campaign planning may take the form of a literature review to identify existing research to assist in clarifying the nutrition problem including qualitative and quantitative KAP or other surveys. If resources permit a cross sectional, quantitative baseline survey could also be undertaken to later compare findings from a post-intervention KAP survey conducted following the SBCC campaign implementation. The qualitative survey with SADC stakeholders undertaken for this strategy identified a number of gaps and challenges contributing to problem behaviours. This included poor knowledge about signs of symptoms of malnutrition, appropriate complementary feeding behaviours, and attitudes, perceptions and social norms which inhibited beneficiaries from adapting recommended behaviours.

7. MEETING NUTRITIONAL NEEDS

Another important aspect of defining and understanding the problem was to examine existing program guidance on nutritional needs as well as gap analysis across SADC and ESAR member states[12, 29]. Recommendations highlighted the availability of specific foods and summarized the main food and micronutrient gaps, while including key policy and programmatic recommendations. Based on the regional evidence collected to date, there are a number of micronutrients of most concern for young children. These include deficiencies in iron, zinc, iodine, vitamin A and calcium, with folate also being of potential concern. Protein food sources that have been identified as being relatively available in number of Member States

include, chicken liver, beef liver, sardines, beef, kale, eggs, lentils, milk and groundnuts. Based on this program intelligence problem behaviours which could be addressed as part of this strategy have been identified (see Appendix 1. – IYCF Behavioural Analysis).

While referencing these regional documents, Member States are encouraged to also continue conducting their own studies in specific geographic areas to identify locally available, easily accessible, affordable and socially desirable foods as well as the development and promotion of recipes ideas for IYCF vulnerable groups. Biofortification, fortification and supplementation, which are already institutionalised in a number of Member State programs, are also important in helping to fill nutrient gaps, particularly where food insecurity, social norms and taste preferences make MDD challenging.

Recommendations for continuous improvement include the following:

- Adoption of best practice formative research and needs assessments to identify target audience and stakeholder needs and wants. Quantitative, cross sectional, SBCC post-intervention surveys can also provide important strategy intelligence for design of subsequent SBCC campaign phases.
- A baseline survey of the first phase campaign can by bypassed by conducting segmentation analysis of SBCC campaign aware and campaign unaware groups to identify any significant changes resulting from the SBCC intervention. This survey can then form the baseline for the Phase 2 SBCC campaign interventions.
- Regional SBCC strategy endorsed by member states and strategic components of the Action Plan implemented to reap the benefits of the transformative program of innovation, sharing of best practice approaches, standardising and integration of methods, instruments and tools.
- Support best practice approaches by engaging SBCC Technical Advisors, Private Sector Partners and Academic Think-Tanks to publish findings and build on the programming science supporting regional approaches.

Step 2. Identify IYCF Target Audiences

A broad number of SBCC campaign target audiences were identified by stakeholders as worthy of consideration for SBCC interventions. Depending on the specific needs of country programs, gap analysis and findings of post intervention surveys, SBCC campaign's may be adapted to address the gaps with more targeted interventions to vulnerable or influencer groups.

8. TARGET AUDIENCES

The need to achieve behavioural impact at-scale with nutrition SBCC campaigns indicates that the reach of SBCC messages and interventions to most population groups will need be broad. However, given the identification of specific high-risk and Most-at-Risk Populations (MARPs) for malnutrition, there is also the need for targeted, more intensive interventions, to these groups. Consideration of priority target groups also needs to account for their accessibility to media, community or other interpersonal messages, interventions and resources, and the fact that priority target groups will also need to be accessed, to evaluate the efficacy and behavioural impact of SBCC approaches. Given these considerations, recommended target groups for regional application are as follows:

8.1 Priority Target Audiences

- Women of reproductive ages of 16yrs-35yrs.
- Husbands and partners of women of reproductive ages.

Priority audiences may include a focus on younger, lower income, rural, vulnerable groups, most-at-risk populations (MARPs) and hard-to-reach populations, namely a) Remote Rural b) Nomadic and Border populations c) Urban and Rural Poor, e) People living with HIV/TB; and f) Ethnic Minorities.

8.2 Secondary Target Audiences

- Younger/Adolescents (females and males) moving into the reproductive age ranges.
- Broader general population 16-65 yrs of age.

General populations include those residing in geographically remote and underserved program areas.

8.3 Tertiary/Influencing Groups

Another group, which has been identified as an important influencer group in any SBCC advocacy efforts, includes opinion leaders and key community influencers operating in community social structure channels. It will be important to elicit support from these influencer groups which could include the following opinion leaders and flag bearers for the program:

- Health Care Providers and Community Health Workers.
- Influential Family Members – Grandmothers/fathers, aunties, elder siblings, other family members.
- Community Influencers - MPs, Local Leaders, Religious leaders, Faith Healers, Mothers Groups, Workplace managers and other respected community members.
- Social Influencers – Celebrities and other Role models.
- Academia – Academic Staff at Secondary schools, Colleges and Universities and School Health staff.
- Civil Society, International NGOs and the Donor community.

Step 3. Set Campaign Behavioural Objectives

The needs assessment identified four 'supply-side' strategic objectives for the regional SBCC strategy. They include 1. Increased sharing of evidence-based nutrition interventions and resources; 2. Easily adaptable interventions to address nutrition priorities; 3. The need for consistent national and regional frameworks and performance indicators, and; 4. Embracing innovation to drive transformative change to turbocharge the nutrition program.

However, SBCC campaign behavioural objectives to support 'demand-side' program beneficiaries are also provided for regional consideration. Important to note is the fact that the behavioural objectives need to address the behavioural determinants identified in predominant behavioural theories and the needs assessment as well as a number of social determinants which may be impacted through SBCC approaches.

9. SBCC BEHAVIOURAL OBJECTIVES

The following awareness, knowledge, perceptions and behavioural (AKAB) objectives are recommended to achieve successful nutrition outcomes across the region. The objectives account for the capacities of the various audience segments and their 'Stages of Change'. It should be noted that SBCC campaign objectives are designed to impact on the overall program outcomes, over the course of the strategy while individual SBCC campaigns need to focus on achieving KAP indicators or address the 'behavioural determinants' to support the achievement of successful IYCF program outcomes (see Appendix 2 - SBCC IYCF indicators). Thus, the objectives are framed with the understanding that participants with good capability and motivation may move quickly through the stages of change. However, also acknowledged is the fact that more vulnerable groups may take more time to change given their lower capabilities, skills and confidence to make the recommended changes. AKAB regional IYCF SBCC objectives are as follows:

Raise AWARENESS

- Set the SBCC campaign agenda through an integrated, synergised, multilevel programming platform.

Build KNOWLEDGE

- On how to easily identify malnourished children.
- The need for exclusive Breast feeding for first 6 months/Complementary feeding/MDD 6-23 months.
- On locally available, easy to source, low-cost, nutrient dense, high protein foods (recommendations on foods may differ from country to country).

- On preparation and recipe ideas for complementary feeding.
- Locations of Health and Support services and the need for regular visits.

Change ATTITUDES and PERCEPTIONS

- Attitudes toward the efficacy of breast feeding over infant formulas.
- Attitudes toward existing social norms which undermine good nutrition practices.
- Attitude toward the quality of the locally available foods.
- Risk-perceptions about harms caused by malnutrition.
- Perception that caring for children is a women's responsibility.
- Capability—Self-efficacy perceptions/competencies, confidence and motivation toward behavioural changes.
- Intentions toward trialling the recommended behaviours.

Modify BEHAVIOURS

- Increased trialling, adoption, maintenance and advocacy toward IYCF behavioural recommendations (see Appendix 2 – IYCF Performance Indicators).

Recommendations for continuous improvement include:

- Aim for SMART Objectives – Specific, Measurable, Actionable, Relevant and Timebound. If an objective cannot be realistically achieved or measured it should not be included.
- Behavioural objectives may likely change with different phases of the 5-year term of the SBCC strategy campaigns as some priority target groups move along the behaviour change continuum, while difficulties with change may be identified with other risk groups.
- Other behavioural objectives may be included with these objectives based on the specific needs of member state campaigns and identified program gaps.

Step 4. Develop Workplan and Allocate Resources

Workplans are an essential step in SBCC strategy development to identify key priorities, strategic actions and specific activities. Additionally, allocation of human and financial resources need to be identified as well as multisectoral partners who will support the activities. Last, is the need for realistic timeframes to conduct the broad range of SBCC activities and report on the findings. (see Appendix 3 – SBCC Action Plan)

Recommendations for continuous improvement of workplans include:

- Build capacity with Regional and National Technical Reference Group (TRG) partners to adapt standardize and optimize workplans for annual SBCC campaigns. Following endorsement of templates and tools, institutionalize approaches across all member states.
- Identify budget estimates for the broad range of activities to support the intensive programming phases of the SBCC campaigns, and work with Governments, donors and partners to achieve cost-share arrangements to provide adequate budgets and human resources to pilot regional adaptations and supporting materials across a number of member states.
- Organize tasks in a timeline and clarify specific actions and dates for completion by the various partners. Build in time for relevant approvals through Coordinating Committee structures.
- Assign people/agencies responsible for each task and synergize SBCC activities to achieve population level impact.
- Get approval and commitment from management and partners, and promote further engagement for a synergized roll-out of activities.
- Be realistic but also ambitious with Workplan activities to ensure continuous improvement of SBCC interventions.
- Continue to advocate for funding for the entire term of the strategy 3-5 years, subject to successful achievement of results following each phase of activity.

Step 5. Build Partnerships/Coordinating Mechanisms

Good coordination and multisectoral support at District, Provincial, National and Regional levels are required for true integration of SBCC approaches and the achievement of optimal programming efficiencies.

10. SBCC COORDINATING MECHANISMS

It is evident that existing coordinating mechanisms already operate in SADC to manage the nutrition program[61]. A number of Member States also have well developed multisectoral coordinating mechanisms for nutrition which can also manage the SBCC component. Technical Working Groups for SBCC may need to be established comprised of specialists with core competencies in SBCC programming. The frequency of Technical sub-Committee and other coordinating committee meetings varies, depending on country capacity and programming requirements. These activities will need to be stepped up during intensive programming periods.

Recommendations for continuous improvement include:

- SBCC coordination should be integrated into the most high-level government committees to ensure strong political will and support for the strategy.
- Where multisectoral representation is not evident, membership should be expanded to include other government agencies, NGOs, civil society and private sector partners with core competencies in desired SBCC programming areas.
- More regular meetings should be conducted in the lead-up to intensive campaign programming periods. Good agendas should be maintained to identify various committee members' responsibilities.
- Services should be outsourced to private sector partners for technical areas of SBCC media production research and implementation with the focus being on adaptation rather than 'reinventing the wheel'.
- Effectively demarcate roles for Government, NGO and private sector partners to leverage the limited human and financial resources and optimize program impact.
- Produce implementation work-plans that include delegated agencies, timing/phasing considerations, Steering Committee and sub-Committee inputs, approval points and adequate budgets.
- Adapt regionally approved, pre-tested, best practice communication concepts, messages, campaign brands and positioning– and synergize across all IEC materials and activities.
- Where capacity permits, conduct additional multi-country communication pre-testing of adaptations and report results and recommendations to SBCC sub-Committee members and partners. Amend and produce final resources in accord with sub-Committee recommendations.

Step 6. Build SBCC Core Competencies

Although, communication campaigns have been conducted and many resources produced, there remains considerable challenges to achieving strategic, evidence-based SBCC programming at-scale. Capacity to evaluate SBCC interventions for behavioural impact has also been identified by stakeholders in considerable need. IPC capacity challenges are also evident with front-line fieldworkers who are in daily contact with caregivers. Many health care workers are also not sufficiently resourced to provide a consistent range of simple nutrition recommendations. A number of other technical SBCC activities related to program development, implementation and evaluation identified from the stakeholder survey, also appear in need of capacity building with 46% of survey respondents believing there was low or very low capacity for SBCC.

Recommendations for continuous improvement include:

- Identify SBCC capacity gaps and build core competencies - A SADC Country Scorecard comparing major IYCF capacity indicators across the region was seen as very useful/useful by 74% of member state respondents.
- Create an online repository of best practice IEC materials for IYCF SBCC that can be easily adapted by all member states.
- Develop country scorecard indicators and implement a survey across member states to rate operatives according to agreed-upon regional SBCC indictors. Use findings to provide relevant training and technical support.
- Provide SBCC indicators scorecard scores on an online web-portal so member states can compare their status and specific needs in relation to other countries in the region - 74% of stakeholders believed such a Dashboard comparing major IYCF indicators across the region would be very useful/useful.
- Develop a Regional SBCC programming 'Centre of Excellence' in one or more SADC Member States with good existing capacity. Engage public and private sector partners to build SBCC core competencies through training, capacity building and institutional strengthening of member state operatives.
- Integrate all activities through a regional Technical Working Group (TWG) under the SADC Steering Committee on Food and Nutrition Security and advocate for improved capacity for nutrition SBCC and other public health priorities (see Fig. 3)

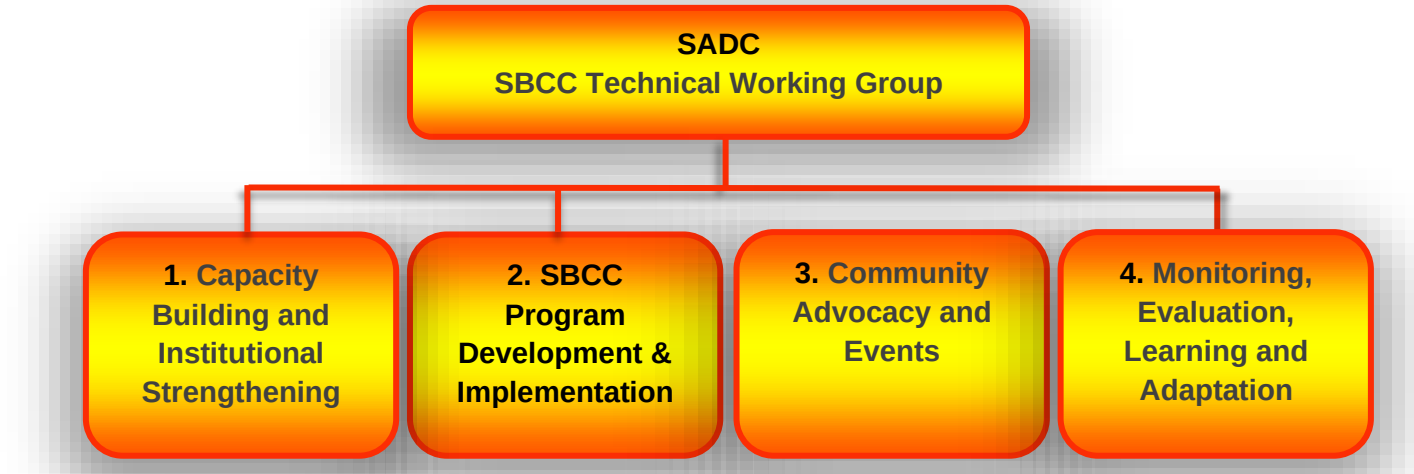

Figure 3. *Core competencies required to operationalize evidence based, best practice SBCC Programs.*

Step 7. Develop Key Messages and Approaches

11. SBCC STRATEGY MESSAGES

A criticism of nutrition campaign messages in the region is that they currently focus on simply providing information rather than engaging audiences in more compelling ways. Given the considerable creative skills and competencies required to develop and frame emotionally engaging messages that will resonate with audiences across all Member States, more creative messages may add the best value and greatest efficiencies in adopting regional approaches.

Recommendations for continuous improvement include:

- Development of a regional creative messaging adaptation approach, through a 'Prototype Campaign-in-a-Box' and piloting the approach. With this in mind, the following are principles for message designs which can be applied to any nutrition messaging in the region:
- Messages need to align with SBCC Campaign BEHAVIOURAL OBJECTIVES derived from the SBCC Strategic Planning Cycle - Planning Stage, gap analysis and impact data gleaned from previous campaigns in the region.

- Messages should be pre-tested to ensure they culturally resonate with target audiences to set the program agenda, change attitudes, shape new social norms, build competencies and confidence to mobilise social and behavioural change.
- Messages need to "touch the heart" with powerful emotional appeals and also "hit the head" with often-repeated, simple, and achievable, recommendations.
- It's important to understand the "barriers to change" or what stops people from making the recommended behavioural changes.
- Messages should aim to "reduce the hurdles" —both psychological and social— thereby, making perceptions and intentions toward the behavioural changes more accessible to audiences.
- Messages should be layered for the different media applications with 2-3 priority messages only delivered across mass media TV and radio spots of short duration, whilst a more comprehensive range of messages may follow the priority messages for community and IPC approaches of longer duration, and where feedback loops from program beneficiaries are available.

11.1 IYCF Behaviours

A number of Regional and Global reports highlight the desired behaviours to be promoted for SBCC campaigns[31,49,62,63,64]. The stakeholder consultations also uncovered a number of additional problem behaviours which may need to be addressed by various member states. Although, the focus on desired behaviours or – 'reaching our destination' – is important, equally important is the 'journey of behavioural change'. SBCC programmers need to take that journey with their IYCF beneficiaries while checking on them regularly to ensure they have appreciated all aspects of the journey before ultimately reaching their destination (see Appendix 1. – IYCF Behavioural Analysis).

Step 8. Select Communication and Dissemination Channels

A broad range of distribution and communication channels have been used across SADC Member States, with preferences for Provincial or District level SBCC channels as a likely result of financial constraints. Some synergies have been attained with multilevel communication activities directed through National, community and IPC channels of communication. However, community resources are limited to donor funding rounds and differing levels of engagement. This means the sporadic range of materials produced to support IPC are rarely updated with few functioning logistics programs for core materials identified.

Recommendations for continuous improvement include:

- Provide regional technical support to assist member states toward more cost-efficient, high-reach and frequency, media delivery and channel plans. Include best practice plans on a regional web portal.
- Adopt a multilevel, communication platform utilizing a range of mass media, community and interpersonal communication (IPC) channels of communication.
- Create SUSTAINABLE PROGRAMMING MECHANISMS for message dissemination by developing mass media public health policy initiatives to ensure at least 60 mins of free airtime (30 mins prime time and 30 mins off peak) on national TV and radio networks.
- Demarcate member state partners to conduct concentrated SBCC programming on multiple channels, during annual "campaign periods" and evaluate campaigns and media plans for behavioural impact
- Use evidence-based, scientific media plans based on GRPs and review the plans following impact evaluation to develop an optimal programming model to achieve "Best Buys"[65].
- Develop a Communications Resource Information System (CRIS) for continuous supply and updating of core IEC materials for SADC member states and work with INGOs to adapt and disseminate the materials as required to build recall, recognition and favourability toward the SBCC program brand and call to action, over time.

Step 9. Implement the SBCC Campaign

A number of communication campaigns to support IYCF behavioural change have been implemented in the region. The predominant focus is on disseminating nutrition information to vulnerable groups. The stakeholder survey identified a broad number of themes have been covered in the varying Member States for 15 key IYCF topics including: Breast Feeding (97%), Early introduction of Breastfeeding (84%), Exclusive Breastfeeding 0-5 Months (95%), Complementary Feeding (92%) and Diversifying the Diet (86%).

Implementation issues arising from the stakeholder needs assessment, identified little understanding as to the optimal duration and intensity of SBCC activities required to achieve impact at-scale. Additionally, concerns have been expressed by some stakeholders on limitations in financial resources and the capacity of community workers to support population-level programs. There is also a lack of understanding on how communication campaigns targeting specific behaviours operate within the overall programming cycle of nutrition related activities, which run continuously across all jurisdictions. Given these technical and financial resource constraints, there may be sub-optimal cut-through at population levels with SBCC nutrition programs. This situation is likely compounded due to the current focus on clinical interventions with prevention activities not given a high enough priority in a number of resource-constrained member states.

Recommendations for continuous improvement include:

- IYCF SBCC tools and resources to be developed at regional level—Campaign-in-a-Box—to support member states to achieve multilevel, synergized, SBCC campaign rollouts.
- Regional support should include the development of scientifically based media plans with adequate reach and frequency (identified through Gross Rating Points [GRPs]). Approximately 400GRPs over 4-6 weeks can provide high reach and frequency of campaign messages.
- Regional policy initiatives should be explored to provide the optimal efficiencies in mass media message penetration and frequency of messages at population levels.
- Dissemination plans require SBCC community resources to be distributed prior to the campaign launches, in readiness for community dissemination through National, Provincial and District networks.
- Following provision of adequate training and community resourcing, National, Provincial and District level operatives should be mobilized for an intensive 4-6 weeks of community-based and IPC programming, activities and events.
- A concentrated multi-level MASS MEDIA UMBRELLA should be executed during the same time period, to support a broad range of community and IPC activities and events. Evidence indicates approximately 100 GRPs per week should be the aim with TV and radio channel plans, to achieve at least 70% reach of target audiences.
- Advocacy for SBCC campaigns should include national and provincial launch activities attended by leaders to demonstrate urgency and political will to stem nutrition problems.
- A synergized, integrated raft of activities conducted by a range of multisectoral partners can optimize program delivery and achieve behavioural impact at-scale.
- Paid media activities should be supported with 'earned-media' public relations and advocacy activities to generate interest and 'hot news' stories.
- Engage highly credible "Program Champions" – Powerful women, Celebrities, Local Leaders and Mothers who have seen improvements in their children's health as a result of improved IYCF practices.
- Annual, intensive, integrated SBCC interventions should be conducted for the 5-year term of the strategy with each Phase of activity building on gaps identified in previous campaign evaluations.
- Develop integrated social media initiatives, and trial the activities to build programming capacity and evidence on what works – Best buys and Return-on-Investment (ROI)[65] – for future SBCC interventions.

12. ILLUSTRATIVE ACTIVITIES

A number of SBCC implementation activities are being developed as part of regional efforts to achieve greater efficiencies in programming, while adopting best-practice approaches to SBCC campaign planning, development, implementation and evaluation. The Campaign-in-a-Box will adopt many of the following activities and provide supporting resources, while other activities could also be considered by member states with programming capacity.

The SBCC campaign implementation stage has been likened to a powerful orchestra of players, with all instruments well-tuned and playing in harmony, to provide a compelling symphony to emotionally engage all audience members and move them to action. With this in mind, the following SBCC activities could be considered.

12.1 Community Level Activities

The Southern African region has many diverse cultures, religions and traditions. However, there are also many similarities across the region. Almost all SADC cultures are steeped in oral traditions, with the large rural sectors of member states in particular, dependent on vernacular, dialogue-oriented, interpersonal communication (IPC) for their health information. A key benefit of IPC is that it can provide an interactive environment where nutrition messages can be delivered from respected sources to beneficiaries of the programs who are the message receivers, with the process also providing feedback and further interaction. Therefore, an important channel of communication in stemming the tide of malnutrition in the region is to build the momentum for social mobilization, and behavioural change at community levels.

Community engagement and participation in SBCC activities can lead to more positive and sustained social and behavioral change. Community ownership also greatly increases the effectiveness and sustainability of the interventions, as the activities are not perceived as something external, but rather as ones where the community can play an important role. Therefore, IPC delivered through community channels, can be one of the most successful approaches to encourage modification of IYCF problem behaviours. This is particularly so in rural areas where literacy is lower or local vernaculars predominate over national languages. Additionally, access to mass media, social media and other channels of communication are also more restricted in these community environments. Community activities to remedy the challenges include the following activities:

12.1.1 Training and Capacity Building

If SBCC campaigns are likened to an orchestra, training is an essential first step in teaching members how to play their instruments, and to ensure that the orchestra plays in-time and in-tune. If well enacted, training can provide a more powerful and emotionally resonant symphony to follow. Although, training and capacity building is an important feature of SBCC technical skill development at Regional and National levels, equally important is the need to build the capacity of the large numbers of community front-line health workers, volunteers, mothers' groups and local-level opinion leaders. This will support the delivery of a number of purposive, standardized, messages to carers in the reproductive age ranges, at every personal contact.

Discussions with front-line field workers in many jurisdictions highlight the lack of basic resources they have to support the delivery of key IYCF recommendations. These workers are also tasked to work on a broad range of other health priorities and have limited time to deliver IYCF messages or conduct growth monitoring. Feedback indicates that health volunteers usually dedicate the most time to programs which have provided training or resource incentives or small stipends for case detection or the delivery of medication and health advice. Given the range of health priorities and the lack of current resourcing for IYCF SBCC, additional training programs need to be conducted as well as Training-of-Trainers (TOT) and Peer Education approaches to leverage the broader dissemination of accurate nutrition information through IPC approaches.

At a Regional level, efforts should be made to identify the optimal resources for front-line field workers to support delivery of key IYCF messages and adapt these resources for all Member States. Ongoing technical support from local NGOs may also be required to enable the process of skills development, confidence and capability of health workers to deliver effective messages to their constituents. SBCC training and capacity building outcomes could include the development of a limited range of resources to support IPC, as well as other culturally relevant activities and events. An aspect of the training should ensure that learning's are translated into realistic and achievable IPC interventions with agreed upon deliverables, with monitoring and evaluation of community activities being an integral component of an intensive, well-resourced program of IYCF community-based interventions, supported by a broader, SBCC 'Mass Media Umbrella'.

12.1.2 Advocacy

Advocacy is an important member of the orchestra, providing a greater resonance to the symphony and assuring that all instruments play in tune. As such, advocacy is an integral aspect of Regional and National level activities as well supporting sensitization and social mobilization at community levels. Advocacy occurs continuously but is stepped up during SBCC campaign intervention periods to build the momentum for change. Advocacy can include timely events attended by community opinion leaders and role models, with these and other advocacy activities designed to set the program agenda, demonstrate political will to address the problem and add-value to SBCC efforts through purposive advocacy approaches conducted through community social structure and social media channels.

Advocacy training can provide skills, identify key IYCF messages and Question and Answer (Q&A) sheets to build opinion leader's confidence in discussing nutrition issues within their constituents. Opinion leaders to be considered for advocacy training could include local politician's, local leaders, religious leaders, traditional healers, journalists, business leaders, celebrities, sporting identities, musicians, artists and other influencers. Following training, incentives such as IEC materials and merchandise could be provided to empower advocates to promote nutrition issues within their jurisdictions. Advocacy processes are also a key feature in any efforts to raise community awareness of the scale of malnutrition harms and the importance of preventative approaches.

12.1.3 Community Theatre and Enter-Educate Events

An important part of any symphony is that it entertains the audience while providing deeper emotional resonance and message retention. Community engagement approaches adopted by many member states are an appropriate mix of traditional and contemporary media. These 'enter-educate' events are designed to first, entertain the public through engaging activities incorporating music-dance-and-drama (MD&D)—singers, musicians, acrobatics, circus troupes, and community drama. In this way, educational messages on nutrition and other public health issues can be imparted using emotionally powerful and culturally resonant themes featured in the dramatic and entertaining executions. Enter-educate events do not require literary skills or clever speaking to be effective. Theatre communicates with the whole community; it appeals to community emotions, passions and prejudices. It is an entertaining way of sharing information, with both adults and children learning their best when they are entertained and engaged in the activities.

If well designed, enter-educate approaches can break through language and cultural barriers to be extremely useful behaviour change communication tools, but activities can be costly to implement at-scale. A recent innovation for IYCF which will be developed as part of the Campaign-in-a-Box, resources involves EMO-DEMOS (Emotional Demonstrations) which can provide fun, community engagement processes to prompt thinking around current and proposed IYCF behaviours. Recommendations for intensive community-based enter-educate media initiatives is to focus these interventions to high-risk settings given the relatively high delivery costs. Enter-educate activities can also involve layered, culturally nuanced themes and messaging, so it's recommended to adapt existing, pre-tested and well evaluated approaches to ensure the messages

resonate in local risk-settings. MD&D activities should also be integrated with the broader platform of SBCC activities to build on the agenda-setting function of multilevel, synergized activities.

12.2 National Level Activities

If a SBCC campaign is likened to a symphony, then mass media is the percussion and brass sections of the orchestra, providing greater depth and resonance to activities while 'trumpeting' the call-to-action. At a National level, mass media has the undeniable power to support behavioural change at population levels, while mobilising support for community based SBCC initiatives. There are a number of mass media channels identified by stakeholders, which have broad reach in member states. These channels can rapidly raise awareness of a priority health program like IYCF, set the program agenda, and build the momentum for change. Many of the resources and activities to follow will also be provided through the Campaign-in-a-Box online resources for easy adaptation to local jurisdictions.

12.2.1 Radio

Stakeholder feedback and available data indicates that radio has the widest reach among mass media in most SADC settings, with the exception of upper middle-income countries where TV prevails. FM radio stations are well listened to in many urban settings with AM and community radio being more effective with rural populations who prefer communication in local vernaculars. Community radio also offers opportunities for local leaders and opinion leaders to advocate for the key IYCF recommendations among their constituents.

As well as purposive Radio Spots of limited duration, which have been pretested to deliver 2-3 specific messages and a call to action, Radio Dramas can also provide more layered, culturally nuanced, socially relevant and entertaining messages. Extended radio dramas can also explore the underlying causes of resistance while promoting the benefits of complying with behavioural recommendations on breast-feeding, complementary feeding and other key nutrition behaviours. Given the potential costs for programming, Radio Dramas also need to be well planned and executed to synergize with other media, community and IPC communication platforms, to provide the best impact at-scale, with media plans carefully developed to run over the intensive programming periods.

12.2.2 Television

Television ownership and coverage, especially in urban areas, has been steadily expanding across the region. Television is the now the mainstay communication channel in the more developed SADC member states and is also a rapidly emerging medium across lower-income countries, with inexpensive Chinese television sets coming onto the market and high interest in the visual impact and novelty of television in rural areas. An important aspect of Television is the additional impact achieved through compelling, graphic imagery.

Challenges for television are the high costs of purchasing media plans across the region and the relatively low frequency of messaging achieved as a result of 'light media plans'. Opportunities at a Regional level are for improved advocacy and policy initiatives to ensure Public Service Announcements (PSAs) which are a health priority, can be disseminated across member state, National and private sector TV networks through free-to-air media plans provided for Government priority health priorities. Additionally, Public-Private-Partnerships (PPPs) with media providers can provide additional 'bonus spots' – with at least 1 free spot provided for every spot purchased – as part of the networks Social-Cause-Related-Marketing (SCRM) activities.

12.2.3 Newspapers

Newsprint was not often mentioned by stakeholders as a primary media channel. However, newspapers can provide SBCC opportunities through 'long-copy,' informational approaches and topical news stories generated through media advocacy activities. Although, access to daily newspapers in rural areas drops-off rapidly, as does the reading culture in more remote areas, newspapers remain an important medium for opinion leaders, with readership far exceeding circulation.

Every member state has National and Provincial newspapers which are influential, as well as a host of other local newspapers. A number of other international newspapers and magazines round-out the market for print news. The daily newspaper's editorial policies provide lively debate, with the medium's primary audience segments for IYCF being policy makers and educated elites. Opportunities arise through working closely with journalists to generate more positive, purposive coverage for nutrition and IYCF programs as well as human-interest pieces highlighting the scale of the problem and success stories. To ensure positive coverage in print media, continued support is required of NGOs and other partners through media training to generate coverage of SBCC Campaign Launches, Creation of Media Events, Development of Media Releases to support print based-stories setting the IYCF program agenda and influencing opinion leaders.

12.2.4 Outdoor Media

Outdoor media can provide nutrition SBCC added impact, memorability and longevity, and is also accessible to large numbers of people in rural and urban areas. There are some opportunities for targeted approaches to billboards in higher-risk areas, although messaging needs to be pictographic, and the billboards or wall-brands need to be located in secure areas.

There appears to be limited experience with nutrition outdoor media messages delivered through stand-alone signs, wall branding and vehicle stickers. A potentially cost-effective and relatively untapped Outdoor Media opportunity is bus, taxi and other public transport signage with millions of urban and rural commuters using public transport on a daily basis. Outdoor signage and campaign branding with key recommendations can also provide 'captive audience' reminders when messages are placed inside of public transport. 'Wall-Branding' on highly visible, public buildings and Community Health Centre sites is also currently underutilized and can also extend the life and reach of SBCC messages while provide timely reminders to patients attending clinics. Once these sites are established, site rentals can be ameliorated over coming years. Given the fact that mobility is a characteristic of a number of vulnerable rural population groups, outdoor media should be more fully explored as a potentially important means of message dissemination.

12.2.5 MHealth and Social Media

If digital media were part of an orchestra, they would be the strings section, allowing soloists and virtuosos opportunities to move the audience with deeply personalised performances. Mobile phones are prolific across SADC member states with upper middle-income countries like Lesotho and South Africa already moving to 5G networks. In the case of member states with high penetration of advanced phone technologies, MHealth apps could be reviewed and adapted to support IYCF behaviours. Lower-income member states are more limited in mobile phone penetration with more rudimentary phone technologies available for transmission of simple SMS and WhatsApp text messages. Nevertheless, mobile phones provide excellent opportunities for dissemination of low-cost messages to at-risk populations, once a database of interest groups is established. Stakeholders should work with mobile phone providers to achieve low-cost dissemination of purposive messages at a number of discrete occasions, during intensive SBCC programming periods. Messages could be accompanied with associated audio mnemonics[A] of the SBCC campaign jingle or other catchy tunes, to support recall and engagement. Referral options for health care services, and multinutrient supplementation can also be provided, based on the location of subscribers.

Social Media – Facebook, Twitter, Instagram and other popular social media platforms, can also offer low-cost, high-reach, targeted interventions to primary nutrition audiences of young mothers and fathers. However, access to MARPs in lower income countries is greatly restricted on social media given the need for 4G phones and the high costs of streaming data in many locations. The objective with social media in upper-

[A] Mnemonic devices are patterns of ideas, presentations of behaviours, audio cues or associations which are designed aid the memory to readily recall the associations when they are seen across a number of settings.

middle income member states is to provide posts which represent 'Real Stories of Real People', rather than being perceived as 'advertising content', which is often viewed with scepticism by social media users who seek connection. The use of Opinion Leaders and Social Media Influencers with a high number of local followers is also a consideration, as long as the influencer is not seen as promoting a range of causes and products, simply to make money. Success stories of real community members dealing with the nutrition challenges identified in this Strategy can provide more culturally resonant content to emotionally engage target audiences. Consistent branding and messaging synergized with other SBCC campaign media platforms and mnemonics is essential in building campaign recall across the range of interventions as well as providing referral options and other incentives to support the social mobilization and behavioural change.

12.2.6 IEC Materials Development and Delivery

A critical feature of any nutrition program is the need to build nutrition health literacy, by improving knowledge, and changing attitudes and perceptions of MARPs, who may be fatalistic, and lacking in confidence and skills to make effective health decisions. Posters, Leaflets, Flip Charts, Recipe Cards, Emo-Demo Treatments as well as print-based materials and merchandise, commonly referred to as Information, Education and Communication (IEC) materials, can assist influencers in supporting social mobilization and behaviour change within community settings. A number of IEC resources will also be developed as part of the Campaign-in-a-Box prototype for easy adaptation to all member state settings.

Community IEC materials were cited by a number of stakeholders as being in short supply. This includes publications to increase knowledge on the risks of malnutrition, while providing recommendations on improved dietary practices, and referral options. Other IEC materials will need to be produced in more user-friendly formats to inform health service providers on the key issues and recommendations they need to communicate to their constituents. Given the poor reading culture and lower literacy in rural areas, more visually based pictographic messaging could be developed and scaled-up to overcome these challenges. Rather than widespread distribution, IEC materials should be seen as predominantly supporting advocates and other influencers in their understanding and dissemination of key messages to their constituents, through IPC.

A key feature of any IEC resourcing program is the timely and efficient delivery of materials, when and where they are needed. Therefore, an SBCC IEC materials Communication Resource Information System (CRIS) has been recommended. CRIS can be best achieved by continuous improvement of logistics mechanisms already available in more developed health systems, including humanitarian food distribution programs. Implementing of a CRIS will minimize the current ad-hoc production and dissemination of nutrition SBCC resources, while also allowing for monitoring of dissemination of the materials based on stakeholder request through online order forms. Additionally, an expert panel of SADC member state representatives should review the broad range of IEC materials produced across the region and agree on 6-8 core materials which can be easily adapted using "Shell Templates.' These templates predominantly use non-culturally-specific animations allowing a wide range of languages to be simply inserted into the 'Shells', in readiness for printing.

Step 10. Evaluate the Campaign – Advocate for Findings

13. MELA FRAMEWORK

The Regional Monitoring, Evaluation, Learning and Adaptation (MELA) framework for SBCC is an essential component of Regional capacity building and a Co-design approach. If successful, these approaches will allow for a standardised, discrete set of Regional KPIs to be institutionalised, to assess SBCC program success and comparisons of performance across the Region. This process has already commenced with the ESARO C4D Measuring Results in Social and Behaviour Change Communication Programming and UNICEFs SBCC/C4D IYCF Program Performance indicators (see Appendix 2 – SBCC Performance Indicators).

M&E is the most challenging area of SBCC program activity, with more than 97% of regional stakeholders responding to the online survey, believing a M&E Framework, with key indicators and sample data collection tools, would be a very useful/extremely useful resource. Main challenges to M&E include the complex range of indicators used to measure nutrition programs in the various member states and the different indicators required to monitor the impact of SBCC interventions for IYCF. Additionally, there appears to currently be a greater focus on monitoring nutrition activities (outputs) rather than attempts to demonstrate significant behavioural impact. There is also a poor understanding of the need to demonstrate SBCC program attribution to any behavioural changes through questions in cross-sectional, post-intervention surveys which identify recall of the specific interventions, making target group recall of SBCC campaigns, brands, key messages and calls to action, difficult to assess. As well as impeding advocacy for the success of SBCC interventions, this gap in SBCC research programming capacity may, in the longer-term, impact on donor confidence in continuous funding of programs which cannot demonstrate a good ROI (Return on Investment).

Recommendations for continuous improvement include:

- Behavioural objectives linked to IYCF are very well defined in a number of existing documents and strategy reports. However, performance indicators tied to the SBCC program objectives need to be synergized across the region to identify the optimal number of process indicators, SBCC campaign impact indicators – and their eventual impact on IYCF nutrition program outcome indicators.
- Develop a Regional online Repository of best-practice instruments and tools for Qualitative and Quantitative research and integrate within National SBCC MELA Frameworks.
- Constitute an Expert SBCC MELA Panel to review input and output indicators - internal measures of capacity, skills, program penetration, product and resource distribution, from existing Regional and Global best-practice approaches and seek consensus on KPIs across the Region.
- SBCC KPIs should emanate from behavioural determinants such as Awareness, Knowledge, Attitudes, Perceptions, Behavioural Intentions, actual Behaviours—Trialling, Maintenance and Advocacy of the desired behaviours to reduce-risk and ensure positive program outcomes.
- Establish SBCC campaign Impact Indicators (audience-based measures of individual behaviour change and population-based measures relating to prevalence, service delivery capacity, case detection, treatment uptake, adherence and success.)[B]
- Conduct operational research to generate data for problem-solving and decision making.
- Develop best-practice instruments and tools for formative and evaluative research and implement for demonstration projects to show the efficacy of approaches and use learnings to inform future phases of the strategic planning cycle.
- Advocate for the successes of the SBCC campaigns and elicit Government and donor support for sustainable funding at International, Regional and National levels.

13.1 SBCC Strategy Key Performance Indicators (KPIs)

The SBCC strategy is one component of the broader nutrition program, with strategic, short-term, intensive SBCC campaigns being a major component of the SBCC strategy annual activities. Given these considerations KPIs for SBCC will differ from those of the broader nutrition program. A number of KPIs for the SBCC strategy are recommended for further review and refinement by Member State M&E staff. The following include SBCC process, outcome and impact indicators with suggestions for options on performance mechanisms to measure the KPIs. In some cases, indicators are aggregated with the understanding that they will be disaggregated when converted to items and scales used in post-intervention surveys to measure the SBCC campaigns for behavioural impact.

13.1.1 SBCC Input Indicators

- Establishment and integration of Regional, National, and Provincial SBCC Coordinating Committees.

[B] SBCC Campaign 'Impact indicators' differ from nutrition program impact indicators as there could be 5 or more SBCC campaigns which are conducted over the term of the strategy that will determine successful Outcomes and ultimately the Impact of the nutrition program generally.

- Development of SBCC Strategic Plans/Workplans, Research Briefs and Communication Reports.
- Establishment of strategic Public-Private-Partnerships and Multisectoral action for improved IYCF.
- Regional, National and Provincial infrastructure established – Office infrastructure, Staff, Trainers, Training Equipment, Logistics Systems and other supplies.

Performance measures include government and donor institutionalized coordinating structures, meeting minutes, reports tabled, and infrastructure confirmed through independent audits.

13.1.2 SBCC Output Indicators

- The number of SBCC Advocacy, Social Mobilization and Technical Capacity Building Trainings conducted, and the number of participants attending.
- The Reach and Frequency of Mass Media Message – Radio, TV, Outdoor Media — Signage/Wall Branding/Public Transport Signage, Mobile Media and Social Media posts.
- The number of Community Media Materials disseminated, and Activities conducted –Leaflets, Posters, Flipcharts, Recipe Cards, Edutainment Events, Emo-Demos, Audio-Visuals, Merchandise Loudspeaker Announcements, and other Community Social Mobilization and Communication Activities – Mothers' Groups, Hospitals/Health Centres, Workplaces, Educational and MARP settings.
- Number of Communities and Individuals Trained in SBCC, number of kitchen gardens for improved nutrition established and maintained.
- The degree (Column Centimetres or Number of Minutes) of 'Earned Media' Advocacy Events and Articles generated on Radio, TV, Newspapers Social Media, and other Media.
- Stakeholder and community acceptability of SBCC Campaign materials

Performance measures include government and donor reports, media confirmation schedules, IEC resource logistics reports and Provincial and District workplan reports, and stakeholder feedback via consultation processes.

13.1.3 SBCC Impact Indicators

1. Target Group Unprompted/Prompted recall of SBCC Communication Campaign Brand, Key Messages and Calls to Action.
2. Recall of Community and Media sources of information.
   - Media Channels such as TV, Radio, Outdoor Signage, Mobile and Social Media -
   - Community and IPC channels such as NGO Activities, Community Posters/Leaflets, Recipe Cards and other publications, Merchandise, Health Workers, Local L and other opinion Leaders, Family Members and Peers.
3. Respondent Knowledge - Increase in knowledge of health risks of poor/inadequate nutrition and the benefits of improved nutrition and dietary diversity. Knowledge of local, low cost foods to achieve MDD for children and families.
4. Respondent Salience of program messages, Believability, Engagement and Motivation to change.
5. Respondent Attitudes – Reduction in stigmatizing Attitudes toward breastfeeding, improved Social Norms toward new complementary foods, sourcing and preparation of the foods.
6. Respondent Perceptions - Increased Personal-Risk-Perceptions toward malnutrition, Increased Response and Self-Efficacy Perceptions/Perceived Behavioural Control/Confidence and Capability to Trail and Achieve IYCF Behavioural Recommendations.
7. Respondent Behaviours - Increase in Behavioural Intentions toward recommended IYCF Behaviours, increase in Trialling of the Behaviours, increase in Adoption of the Behaviours and increase in Discussion and Advocacy for the Behaviours with other community members.
8. Campaign Best Buy Scenarios and ROI on Population Level Changes in AKAB.

Performance measures include SBCC Campaign Post-Intervention AKAB surveys and other annual nutrition specific surveys, Media Monitoring Reports and Campaign Budget Reviews.

13.1.4 SBCC (Nutrition Program) Outcome Indicators

- IYCF policies on nutrition implemented and enforced.
- Improvements in children and family BMI, nutrition intake, MDD and quality of life.
- Decrease in risk factors resulting from poor nutrition - stunting, wasting, hidden hunger and obesity.
- Reductions in burden of malnutrition related morbidity and mortality
- Decrease in health care costs and productivity losses.

Performance measures include National Demographic Health and Nutrition Surveys, Economic Household Surveys, Global and Regional Health and Welfare Surveys, and other Development Reports.

13.2 Program Continuous Improvement

Working toward integration of priority IYCF nutrition programs to achieve greater efficiencies and impact-at-scale is an honourable and innovative approach for SADC. It places the agency at the forefront to achieving transformative change across a regional setting, while dealing with the perennial health challenges of malnutrition. However, an integrated SBCC strategic programming approach, embraced by nutrition stakeholders in all the member states, will take time to achieve. As such, the SBCC Program Guidance provided in this Strategy and Action Plan (see Appendix 3.) is the starting point for engagement of all member state nutrition stakeholders on best practice approaches to operationalise their country strategies while building dialogue on how to also improve regional efficiencies.

Quality Assurance (QA) is a process of establishing policies and guidelines to ensure that SBCC programs, products and activities, are of the highest standard. This strategy feature can utilize QA mechanisms for processes such as the International Standards Organization (ISO) standards for World's best practice, UN and other donor standards for QA. QA seeks to develop continuous improvement mechanisms within the strategy to ensure that SBCC programs, products and services are effectively delivered and continuously improved upon. QA processes could include policy initiatives for the range of IYCF prevention programs, activities, events and services being considered or scaled-up as well as QA for SBCC program messages and materials development, pre-testing, production and dissemination.

QA may not have been given enough emphasis in SBCC strategies to date, given the scale of the malnutrition problem and the hothouse environment to achieve contracted outputs. However, once a culture of continuous improvement is institutionalized, the Learning and Adaptation aspects of MELA will provide SADC member states with greater opportunities to move toward more 'Customer Focused' approaches. Member states which currently do not conduct health consumer satisfaction surveys or do not have a 'Patient Charter' enshrined in health facilities, should also work toward this end. This will demonstrate political will to increase the levels of nutrition-client entry, assess, involvement and satisfaction with health service delivery, and other systems approaches, which when coupled with effective SBBC will ensure the success of nutrition programs.

Institutionalizing QA best-practice approaches and using evidence to continuously improve on subsequent phases of the strategy has many long-term benefits. Key factors to support continuous improvement and regional QA of the SBCC component include the need to achieve greater efficiencies through adaptation rather than "re-inventing the wheel". Additionally, the Co-Design philosophy will also allow regional partners to work together to standardize indicators for SBCC MELA and agree on a final discreet set of KPIs for IYCF programs across the region. To be successful, the process going forward will require ongoing QA checks and balances to ensure that all partners are supportive of approaches, and their specific needs and wants are being addressed, as the strategy evolves. This will require considerable dialogue on SBCC regional approaches, as well as continuous monitoring and evaluation of efforts to achieve IYCF sustainable behavioural outcomes.

14. CONCLUSION

The key elements, guiding principles and illustrative activities outlined in this Regional SBCC strategy for IYCF in SADC member states are designed to operationalise evidence-based, best practice, programming approaches across the region. The strategy also provides guidance to build SBCC technical and organizational capacity, participation, ownership and engagement by a broad number of regional partners. If coordinating

mechanisms can be enhanced, and successful partnerships developed, there are considerable opportunities for more sustainable approaches and value-adding initiatives for SBCC programs for IYCF among SADC member states.

Following circulation and endorsement of the Regional SBCC Strategy the real work will need to commence to refine the Action Plan and implement the range of activities required to build technical capacity, advocacy, social mobilization and communication resources for a number of best-practice approaches to be piloted across select member states. Subject to the engagement of key program partners and successful outcomes of the SBCC demonstration projects, it is hoped that these strategic approaches to SBCC programming can be scaled-up and institutionalized across the region. It is believed that the practical program guidance provided in the SBCC strategy, innovative regional approaches and improved efficiencies, will lead to a more intensive rollout of best-practice SBCC interventions to achieve population level impact.

APPENDIX 1.

IYCF BEHAVIOURAL ANALYSIS

BEHAVIOURAL ANALYSIS (LAYOUT OPTIONS)

PROBLEM BEHAVIOURS	BARRIERS TO CHANGE	MESSAGES TO ADDRESS BARRIERS	INDICATORS FOR SUCCESS
BREASTFEEDING • Mothers do not Initiate breastfeeding immediately after birth. • Mothers do not Breastfeed exclusively for 6 months. • Mothers do not Breastfeed on demand. • Mothers do not continue breastfeeding through 2 years of age.	• Lactation problems, cannot express milk, feeling pain during feeding. • Lack of social supports, disapproving social norms for breastfeeding in public. • Livelihoods prevent regular breast feeding. • Attitudes that bottle feeding provide greater freedoms for modern mothers.	• Evidence shows breastfeeding is the healthier more natural approach providing all the nutrients a child needs in the first 6 months. • Breast feeding is an acceptable practice in public settings and endorsed by the Government and practiced by opinion leaders. • There are now workplace family friendly spaces which allow mothers to breastfeed in private.	• Improved knowledge, attitudes, and intentions to exclusively breast feed for first 6 mths. • Improved attitudes, confidence and skills to breastfeed exclusively. • New social norms which accept breastfeeding as a natural health and desirable behaviour.
INFANT FORMULAS • Younger mothers use infant formula and bottle feeding over breastfeeding.	• Misconception that formula is equivalent to breast feeding. • Formula is relatively low cost, easy access and prepare. • Bottle feeding is seen to reduce the social stigma of breastfeeding in public.	• Six months of exclusive breastfeeding can increase your child's chance of survival by six times. • Formulas are a false economy for your infant's health. Formulas contain excess sugars, salt, and fats which are not as healthy for babies.	• Improved knowledge, attitudes, about benefits of breastfeeding over formula feeding. • Reduced stigma and Improved confidence to breastfeed exclusively.
HIDDEN HUNGER • Inadequate food intake food quality that does not meet mothers' nutrient requirements during pregnancy and lactation.	• Mothers do not get enough household food to provide adequate nutrition. • Cultural norms put husbands and children first in the food chain, and women last.	• It's important for mothers to get additional nutrients when they are breastfeeding. • If mother do not get enough food, it can impact on their ability to breastfeed children. • It's important for mothers to eat a balanced and diverse diet rich in micronutrients, energy, and protein.	• Improved attitudes, confidence and skills to source adequate food for the family and provide dietary diversity. • Changed social norms toward prioritizing men's food preferences

PROBLEM BEHAVIOURS	BARRIERS TO CHANGE	MESSAGES TO ADDRESS BARRIERS	INDICATORS FOR SUCCESS
• Deficiency in kilojoule intake and diversity of foods containing micronutrients, vitamins and minerals in young children needed for healthy growth and development.	• Parents do not know the amount of food/serving sizes and dietary options available to achieve adequate daily kilojoule intake. • Mothers and fathers have poor skills and confidence to access food supplementation programs when they cannot meet family needs.	• Messages show visuals of the types of locally available foods to be consumed and adequate serves to achieve daily requirements for mothers who are breastfeeding. • Messages hint at the impact on mothers and children if adequate food is not consumed. • Messages emphasise that food supplementation is available to low income groups and where the food supplements can be sourced.	and portion sizes over women and children. • Improved knowledge attitudes, confidence and skills to source supplementary food programs where adequate food cannot be provided.
COMPLEMENTARY FEEDING • Men do not bring home diverse foods for their children's consumption. • Mothers are constrained by their husbands purchasing and preferences for foods which don't provide MDD for children. • Women do not have the time or resources to establish Kitchen Gardens (KGs) and men do not want to support them.	• Social norms determine that men source traditional, easy to source foods. • Perceptions that dietary diversity is more expensive to achieve. • Lack of knowledge on easy to source, more diverse and nutritious food sources. • Lack of knowledge on which types of foods provide what types of nutrients. • Lack of capability, self-efficacy, skills and resources to create a kitchen garden.	• Emphasise the need to introduce diverse complementary foods at 6 months. • Feed children actively and responsively • Feed children a diverse diet • Feed children with appropriate frequency, with foods of appropriate thickness. • Feed children appropriately during and after illness. • Promote eating of iron-rich/fortified foods and identify the food types. • Eat vitamin A-rich/fortified foods • Messages highlight the benefits of Kitchen Gardens (KGs)and the range of foods which can be grown including vegetables, fruit, poultry, beef and dairy. • Messages provide information on where KGs training and resources are available and incentives to engage.	• Improved knowledge about where to source diverse foods. • Improved capability, motivation and intention to provide MDD for children under 5. • Increase in number of KGs established in high risk settings.
ANEMIA • Mothers and fathers do not address the needs of anemic infants and children. • Fathers spend limited financial resources on non-essential items. • Fathers require mothers to prepare meals to prioritize	• Parents have trouble readily identifying anemic or malnourished infants. • Poverty and other challenges lead to active avoidance/denial of anemia in children. • Fathers put their own food needs above the needs of their partners and children.	• Front line field workers and health workers provide advice on visual signs and symptoms of anaemia and malnutrition. • Health workers recommend mothers attend mothers group meetings to get advice on how to achieve MDD. • Health workers recommend that mothers should attend clinics for Vita A and micro supplements. • Health workers identify high risk children and arrange more regular visits and support to monitor progress. • Resources show the visual signs of malnourished and anaemic children.	• Increase in the number of carers who can identify key signs of malnutrition. • Improvements in carers attitudes and intentions toward health seeking for anemia. • Improved knowledge, capability and

PROBLEM BEHAVIOURS	BARRIERS TO CHANGE	MESSAGES TO ADDRESS BARRIERS	INDICATORS FOR SUCCESS
their preferences over their children's.		• Resources emphasise the importance of MDD for children and provide visual stimuli on easy to source foods and food preparation. • Messages hint at the long-term negative impacts of malnutrition to children and their ability to support the family if nutrition recommendations are not adhered to.	motivation to provide DD foods.
OBESITY • Mothers and fathers use convenience foods from stores that are highly processed and contain added sugars, fat and salt instead of traditional natural foods for IYCF. • Multinational companies spend millions on marketing of unhealthy 'junk foods' to children.	• Mothers have competing demands to work and have no time to breastfeed or provide health food options. • Parents are seduced by marketing of colorfully packaged low cost junk foods and infant formulas.	• Front line field workers and health workers provide advice on signs and symptoms of overnutrition obesity in children and parents. • Messages describe the long-term negative impacts of obesity on child development and later onset of NCDs. • Health workers identify high risk children and arrange more regular visits and support to monitor progress. • Resources emphasise morbidities of undernutrition and overnutrition and highlight easy to source healthy food options and food preparation.	• Increase in the number of carers who can identify key signs of overnutrition/obesity. • Improvements in carers attitudes and intentions toward healthier food options. • Improved knowledge, capability and motivation to provide IYCF, low fat, low sugar/salt foods.
HEALTH SEEKING BEHAVIOUR • Mothers visit PHCs with their children when illness is readily evident but do not get recommended growth or weight checks. • In communities with high malnutrition social norms are such that malnourished children are not perceived as needing treatment or care.	• Waiting times at PHCs are long and level of care is often not adequate. • Clinicians do not see their role as one of providing preventive advice. • Community health workers have other priorities and do not address malnutrition or provide referrals.	• Health workers given support resources with IYCF key messages and training to emphasise their role in malnutrition prevention and care. • Health workers prompt mothers on when the last had a growth monitoring of their child. • Health workers provide advice on simple signs and symptoms of malnutrition. • Health workers highlight the harms that can occur to the child if they are malnourished. • Health workers advise mothers on types of easily accessible nutritious foods. • Health worker provides mother with take home, pictographic recipe cards and plate visualisations showing how to add diversity to traditional diets using readily available nutritious foods.	• Increase in number of growth checks, regularity of checks. • Increase in number of referrals for malnutrition and IYCF to PHCs. • Quality assurance of health care providers and satisfaction reported by patients.

PROBLEM BEHAVIOURS	BARRIERS TO CHANGE	MESSAGES TO ADDRESS BARRIERS	INDICATORS FOR SUCCESS
		• Mass media messages include images of mothers health seeking behaviour in PHCs, and demonstration of positive interactions with health centre staff.	
WASH* • Poor knowledge on hygiene results in lack of handwashing. • Perceptions that diarrhea and other intestinal problems are normal given the high prevalence in some communities. • Water and soap is not available in many rural and nomadic communities so WASH recommendations not followed.	• Communal latrines, particularly in slum settings are unhygienic and not well maintained. • Water pumps often break and are not repaired. • In dry areas water usage is restricted to drinking.	• Poor hygiene can lead to serious illnesses in children under 5 and other family members. • Handwashing with soap can stop illnesses that reduce productivity and require health care. • Handwashing with soap by caretakers reduces the risk of diarrhoea among under-5s by nearly half and reduces the risk of acute respiratory infections by nearly a quarter. • Handwashing should occur at around 12 critical times including after defecation, after changing diapers and before food preparation and eating. • Where WASH practices are challenging handwashing stations should be created in the community to allow for good access to clean water and soap.	• Respondents reporting higher rates of handwashing at critical times. • Evidence of improved sanitation in communities. • Increase in number of handwashing stations.

** In line with strategy recommendations on layering of messages (see section 11. SBCC Strategy Messages) problem behaviours related to WASH initiatives should be addressed through longer duration IPC and community initiatives where sender-receiver loops are available to discuss specific recommendations related to IYCF behaviours.*

APPENDIX 2.

SBCC/C4D IYCF Program Performance indicators

The following IYCF program performance indicators related to nutrition knowledge, attitudes and behaviours have been identified as important in addressing IYCF problem behaviours[1]. SBCC component impact indicators or behavioural determinants can impact on successful outcomes of the IYCF program as a whole.

Program Key Performance Indicators	Desired Behavioural Outcomes/ Behavioural Prevalence	Details
IYCF Program Outcome Indicators	Timely initiation of breastfeeding (%)	Percent of women with a live birth in the 2 years preceding the survey that put the newborn infant to the breast within 1 hour of birth
	Proportion of children exclusively breastfed until 6 months of age (EBF)	Percent of infants aged 0–5 months who were fed exclusively with breast milk during the entire day prior to interview. Exclusive breastfeeding (EBF) means the baby has not received any other fluids (not even water) or foods, with the exception of oral rehydration solution, drops and syrups (vitamins, minerals, medicines).
	Proportion of children aged 6-8 months who received solid, semi-solid or soft foods	Percent of children 6-8 months of age given solid, semi-solid, or soft foods in the past 24 hours prior to the survey.
	Timely complementary feeding rate	Percent of infants aged 6-8 months that are receiving breast milk and complementary foods
	Frequency of complementary feeding	Percent of infants aged 6-23 months that receive breast milk and complementary food at least the minimum recommended number of times per day (two times per day for infants aged 6-8 months, three times per day for infants aged 9-23 months (breastfed and four times per day for non-breastfed 6-23 months)
	Child minimum dietary diversity (MDD)	Percent of children 6–23 months of age who receive foods from 4 or more food groups.
	Child Minimum Meal Frequency (MMF)	Percent of breastfed and non-breastfed children 6–23 months of age, who receive solid, semi-solid, or soft foods (but also including

		milk feeds for non-breastfed children) the minimum number of times or more.
	Child Minimum Acceptable Diet (MAD)	Proportion of children 6-23 months of age who receive a minimum acceptable diet (apart from breastmilk)
IYCF SBCC Campaigns Impact Indicators/ Behavioural Determinants*	***Knowledge Indicators – Target Audiences*** 1. % of respondent lactating women, women of childbearing age, husbands, mothers in law, family members, and community members who know the benefits of exclusive breastfeeding for the infant 2. % of respondent mothers, women of childbearing age, fathers and family members who can cite at least two benefits of continuous breastfeeding at least up to 24 months 3. % of respondent mothers, women of childbearing age, fathers and family members who can cite the benefits of complementary feeding 4. % of respondent mothers, women of childbearing age, fathers and family members who can cite at least four food groups that make up a diverse diet 5. % of respondent fathers who can cite at least two childcaring and feeding practices 6. % of respondent mothers, women of childbearing age, fathers and family members who are aware of the health hazards of using unhygienic practices in food preparation	
	Attitudinal Indicators – Target Audiences 1. % of respondent Pregnant women, mothers, and women of childbearing age, who declare that implementing early IBF is good for the baby's health and growth 2. % of respondent Pregnant women, mothers, and women of childbearing age, who declare that implementing exclusive breastfeeding is good for the baby's health and growth 3. % of respondent Pregnant women, mothers, and women of childbearing age, who declare that implementing adequate complementary feeding is good for the baby's health and growth h ***WASH Behaviours – Target Audiences*** 1. % of caregivers of children under 2 who recall washing hands with soap at the five critical times (before preparing food, before breastfeeding, after changing a baby's nappy, before eating and after using the toilet) yesterday/last night	
	Knowledge Indicators – Service Providers 1. % of respondent health and nutrition workers, community health workers and community volunteers who understand the negative effects of pre-lacteals for the new-born	

IYCF SBCC Campaigns Impact Indicators/ Behavioural Determinants*	2. % of respondent health and nutrition workers, community health workers and community volunteers who know the benefits of exclusive breastfeeding for the infant
	Attitudinal Indicators – Service Providers 1. % of respondent health and nutrition workers, community health workers and community volunteers who believe that EBF is by far better than breastmilk substitute 2. % of respondent health and nutrition workers, community health workers, community volunteers, TBAs, etc. who believe that EBF for the first 6 months might not be sufficient for the babies to grow well 3. % of respondent members of the community (mothers, fathers, in-laws, peers, elderly) who believe it is taboo, against the tradition or not good for a mother to express breastmilk to be given to her baby while she is away.

1. *Key Performance Indicators adapted from UNICEF C4D/SBCC indicators list MIYCF.*
**SBCC program impact indicators contribute to the achievement of IYCF program outcome indicators by addressing the 'behavioural determinants' or factors which contribute to the reducing the risk of malnutrition through changes in knowledge, attitudes and behaviors.*

APPENDIX 3.

SBCC STRATEGY ACTION PLAN

STRATEGIC OBJECTIVE 1. Increased sharing of evidence- based nutrition interventions & resources	**STRATEGIC OBJECTIVE 2. Easily adaptable interventions to address nutrition priorities**
STRATEGIC OBJECTIVE 3. Consistent national and regional frameworks and performance indicators	**STRATEGIC OBJECTIVE 4. Transformative changes made to turbocharge the program**

SBCC PILLAR 1: STRENGTHENED SBCC CAPACITY

Strategic Objective *– Increased sharing of evidence-based nutrition interventions and resources*

STRATEGIC ACTIONS	PRIORITY INTERVENTIONS	WHO	Period	Deliverable
1. *Review SBCC training capacity needs of stakeholders and Member State program partners.* 2. *Develop Tools and approaches for SBCC Training and Capacity building workshops to build SBCC 'core competencies' for SADC nutrition stakeholders.* 3. *Provide stakeholders training and technical transfer to meet needs through technical support (international and national advisors) during development, implementation, and evaluation stages of program evolution.* 4. *Develop indicators for country SBCC capacity scorecard, conduct online survey and collate scores across SADC member states.* 5. *Recommendations for filling training capacity building gaps made to SADC and member state representatives.*	• Conduct SBCC capacity building and technical transfer • Monitor capacity building program for resource sharing and impact at-scale • Provide feedback for continuous improvement. • Continue refresher trainings in Yrs 3-5 of the strategy to maintain engagement.		*Feb 2021* *Oct 2021- March 2022*	*Quality assured training resources, workshops/trainings conducted/participants attended and feedback positive.* *Member state capacity identified for future trainings from online SBCC country scorecard.*

SBCC PILLAR 2: IMPROVED EFFICIENCIES

Strategic Objective *– Easily adaptable interventions to address nutrition priorities*

STRATEGIC ACTIONS	PRIORITY INTERVENTIONS	WHO	WHEN BY	DELIVERABLES
• Adaptable, best practice IYCF SBCC resources.	1. *Identify priority member states and develop prototype adaptable SBCC campaign and supporting resource materials.* 2. *Implement prototype campaign and evaluate for behavioural impact.* 3. *Develop pre-test method and implement beneficiary review against 10-12 standardized indicators for SBCC impact.* 4. *Present findings to regional SBCC Technical Working Group.* 5. *Adapt highest scoring concepts and approaches for regional application.* 6. *Incorporate approved concepts and findings onto regional web portal and advocate for application to other member states.*	*SADC, Member States and Partners*	*March 21* *Sept-Dec 21* *Oct 22* *Dec 21* *Jan 22* *Feb 22*	*Quality assured best practice creative materials, tools and resources identified for adaptation.* *Best practice SBCC Material identified and included on web portal.* *Improved SBCC efficiencies and integration across SADC Member States.*
• *Drive innovation through regional and global nutrition SBCC adaptation approaches.*	1. *Design online SBCC web-portal for SADC member state resource adaptation.* 2. *Provide toolkits instruments and creative materials for planning, design, implementation and evaluation of demonstration project SBCC campaigns.* 3. *Conduct media audit of existing SBCC nutrition materials and resources across all member states.* 4. *Establish Expert Panel of SADC member state representatives to collate and review the broad range of IEC materials produced across the region and agree on 6-8 core materials should be selected which can be easily adapted using "shell" templates.* 5. *Shell templates of core IYCF materials uploaded onto online Web Portal.*	*SADC, Member States and Partners*	*June 21* *July 21* *Sept 21* *Oct 21* *Nov 21*	*Best practice approaches adhered to.* *Member States engaged with online portal and approve of resources.* *Adapted campaigns implemented across SADC member states.* *Portal resources improved and accessed by member states.*

• *Build on the Existing Evidence Base for SBCC's Impact on Nutrition.*	1. *Establish authoritative IYCF academic group from a number of member states.* 2. *Review existing and new SBCC nutrition programs for behavioural impact.* 3. *Draft journal articles for submission to international peer reviewed journals.* 4. *Establish a centre of excellence in a member state with good capacity and advocate for program successes.*		*June 21* *July 21* *Sept 21* *Ongoing* *March 21*	
SBCC PILLAR 3: SBCC REGIONAL INTEGRATION ***Strategic Objective*** *– Consistent national and regional frameworks and performance indicators*				
PRIORITY INTERVENTIONS	**STRATEGIC ACTIONS**	**WHO**	**WHEN BY**	**INDICATORS**
• *Standardized, Regional SBCC performance indicators for IYCF* • *Institutionalize SBCC KPIs across SADC member states.* • *Evidence based approaches to program design and implementation.* • *Building the programming Science* • *Continue to refine and continuously improve on MELA frameworks and online resources.*	1. *SDAC member state representative review SBCC indicators in regional strategy.* 2. *Develop SOW and contract providers to conduct MELA workshop.* 3. *M&E experts from SADC member states identified to attend workshop.* 4. *Workshop materials developed and approved.* 5. *Workshop conducted and consensus on SBCC indicators and performance mechanisms by reached member state representatives.* 6. *15-20 KPIs for inputs, outputs and SBCC impact across SADC Member States (Outcome indicators derived from nutrition program generally).* 7. *Follow-up to ensure KPIs included in future surveys and data collection.* 8. *Finding incorporated into online Web Portal to provide comparisons across Member State settings.* 9. *Country scorecards used for planning of future research and interventions to fill gaps identified.* 10. *Engage SBCC Technical Advisors to work with Donors and Academic Think-Tanks to publish findings and build on the programming science supporting of regional approaches.*	*SADC AND Member State Partners*	*Nov 20* *Feb 21* *March 21* *June 21* *June 21-june 22* *Ongoing* *Nov 21 and ongoing* *2022-25*	*Consultants contracted to review existing indicators and develop core set of 15-20 KPIs -Inputs, Outputs and SBCC Impact indicators.* *SBCC indicators reviewed by member states M&E experts and consensus achieved.* *KPIs institutionalised within SBCC member state programs.* *SBCC KPIs integrated with nutrition program KPIs.* *Planning reports use research findings to inform future program development* *Journal articles accepted in International peer revised literature.*

SBCC PILLAR 4: EMBRACING INNOVATION ***Strategic Objectives*** *– Transformative changes made to turbocharge the program*				
PRIORITY INTERVENTIONS	**STRATEGIC ACTIONS**	**WHO**	**WHEN BY**	**INDICATORS**
• *Advocacy for greater political will to fund best practice SBCC for the term of the strategy.*	1. *SOW developed for providers for advocacy toolkit* 2. *Develop advocacy toolkit for political leaders outlining the scale of the problem, health and development costs, and the benefits of preventative efforts.* 3. *Provide indicative Workplans and budgets for one phase of activity with a proposal for continued funding subject to the achievement of deliverables.* 4. *Advocate for successes of SBCC campaigns using post intervention survey data and seek continued funding to achieve long-term strategic benefits of 3-5 consecutive years of programming.* 5. *Use lessons learned from lead member states to advocate for approaches in other SADC regional countries.*	*SADC and Member State Partners*	*April 21* *June 21* *Oct 21* *Nov 21 Onward*	*Sow developed and policy advisors contracted.* *Toolkit developed and presented to Parliament.* *Political will and funding allocated for the 5 yr term of the strategy.* *Other member states adapt resources and also get funding.* *Prototype campaign resources developed using best practice approaches*
• *Advocacy for regional adaptations of best practice SBCC creative resources and improved efficiencies.*	1. *Promote use of best practice prototype campaign resources and online website through SADC regional meetings and E-Newsletters.* 2. *Use findings from member states that have implemented the campaign to advocate for population level impact.*	*SADC and Member State Partners*	*March 21* *Nov 21 Onward*	*Sow developed and legal advisors contracted.* *New policies drafted or existing policies implemented.*
• *Advocacy for Mass Media policy for monthly allotment of free media airtime on government and commercials channels*	1. *Review select country media legislation for public service allocation.* 2. *Develop SOW and contract government policy legal advisors to review existing broadcasting and transmission Acts for public service announcements.* 3. *Revise or enforce policies which will provide an allocation of at least 30 mins of prime time on all TV and radio stations for priority health programs.* 4. *Develop a programming calendar which allocates the media space to priority health issues over the calendar year.*	*SADC and Member State Partners*	*July 21* *Sept 21* *Oct 21* *Nov 21 Onward*	*Policies debated and enacted by Government and complied with by network providers.* *Media plans enacted to achieve high reach and frequency of SBCC nutrition and other priority health messages.*

• *Advocacy to persuade Decision-Makers that SBCC is critical for tackling malnutrition* • *Advocacy for Family friendly workplace and education policies for young mothers and fathers.* • *Advocacy for Food supplementation policies to support the most marginalised communities.* • *Advocacy for humanitarian food aid for instances of insecurity, natural disasters or pandemic threats.*	1. *Conduct advocacy and capacity building for health and welfare agencies to provide purposive SBCC campaigns across the calendar year.* 2. *Develop SOW and contract providers for development of Advocacy tools for decision makers.* 3. *Advocacy Toolkit to provide SBCC success stories across the region and globally with econometric analysis provided on cost benefits and ROI of implementing prevention programs.* 4. *Conduct targeted advocacy with leaders in SADC member states through regional fora and personal appeals from other global leaders.*	*SADC and Member State Partners*	*Oct 21 Onward* *June 21* *Sept 21* *Oct 21 Onwards*	*Policies enacted in a range of member states. Improved impact at-scale of SBCC interventions* *Improved resilience to overcome malnutrition during humanitarian crises.*
• *Continuous improvement of new policies and advocacy approaches*	1. *Expert Panel reviews member state IYCF best practice policies.* 2. *3-6 Policies to ensure impact-at-scale identified and included in advocacy package.* 3. *Package uploaded onto Web Portal for Member states application to local settings.*	*SADC and Member State Partners*	*June 21* *Sept 21* *Oct 21*	*Post intervention surveys DHS and other population surveys show improvements in AKAB indicators and subsequent malnutrition indicators.*

REFERENCES

1. USAID. Multi-Sectoral Nutrition Strategy 2014–2025: Technical Guidance Brief Effective At-Scale Nutrition Social and Behaviour Change Communication. Available from file:///C:/Users/tturk/Documents/invoices/2020/SMSF/USAID%20at-scale-nutrition%20SBCC-technical-guidance-brief-edit-508.pdf

2. USAID. (2012). CModules: A Learning Package for Social and Behaviour Change Communication (SBCC). Available from file:///C:/Users/tturk/Downloads/sbcc_0_introduction-_usaid_2012.pdf

3. Kim SS, et al. (2018) Large-Scale Social and Behaviour Change Communication Interventions Have Sustained Impacts on Infant and Young Child Feeding Knowledge and Practices: Results of a 2-Year Follow-Up Study in Bangladesh. *J Nutr*, *148(*10):1605-1614.

4. Sanghvi T, et al. (2017). Using behaviour change approaches to improve complementary feeding practices. *Matern Child Nutr*, 13(S2).

5. Lamstein S, et al. (2014). SPRING Working Paper: SBCC Pathways for Improved Maternal, Infant, and Young Child Nutrition Practices. JSI Research & Training Institute, Inc. (JSI).

6. WHO. (2018). Malnutrition Factsheet. Available from https://www.who.int/news-room/fact-sheets/detail/malnutrition

7. UNICEF/WHO/World Bank Group. (2019). Levels and Trends in Child Malnutrition. Available from https://www.unicef.org/media/60626/file/Joint-malnutrition-estimates-2019.pdf

8. SADC. (2020). Synthesis Report on the state of food and nutrition security and vulnerability in Southern Africa. Available from https://www.sadc.int/files/7315/6284/6868/SADC_2019_Synthesis_Report_on_the_State_of_Food_and_Nutrition_Security_and_Vulnerability_in_Southern_Africa.pdf

9. UNICEF / WHO / World Bank Group. (2020). Levels and Trends in Child Malnutrition. Joint Child Malnutrition Estimates: Key findings of the 2020 edition. Available from https://data.unicef.org/resources/jme-report-2020/

10. Haddad L, Cameron L, Barnett I. (2015). The double burden of malnutrition in SE Asia and the Pacific: priorities, policies and politics. *Health Policy and Planning; 30*(9): 1193. DOI:10.1093/heapol/czu110

11. Mahmudiono T. (2016). Child stunting in households with double burden of malnutrition: Applications of behavioural epidemiology. ProQuest Dissertations Publishing, 2016. 10127361.

12. Kinyoki DK, Kandala NB, Manda SO, et al. (2016). Assessing comorbidity and correlates of wasting and stunting among children in Somalia using cross-sectional household surveys: 2007 to 2010. *BMJ Open*. *6*(3): e009854.

13. United Nations Children's Fund (UNICEF). (2020). Improving Young Children's Diets During the Complementary Feeding Period. UNICEF Programming Guidance. New York: UNICEF.

14. Lassi ZS, et al. (2013). Impact of education and provision of complementary feeding on growth and morbidity in children less than 2 years of age in developing countries: a systematic review. *BMC Public Health, 13* Suppl 3: p. S13.

15. Arikpo D, et al. (2018). Educational interventions for improving primary caregiver complementary feeding practices for children aged 24 months and under. *Cochrane Database Syst Rev, 5*: p. CD011768

16. Mostafa Kamal SM. (2011). Socio-economic Determinants of Severe and Moderate Stunting among Under-Five Children of Rural Bangladesh. *Mal J Nutr. 17*(1): 105 – 118.

17. Mozaffarian D, Angell SY, Lang T, Rivera JA. (2018). Role of government policy in nutrition—barriers to and opportunities for healthier eating. *BMJ; 361* doi: https://doi.org/10.1136/bmj.k2426

18. Hossain M, Choudhury N, Adib B, et al. (2017). Evidence-based approaches to childhood stunting in low and middle income countries: a systematic review. *Archives of Disease in Childhood; 102*(10): 903. DOI:10.1136/archdischild-2016-311050

19. Kuchenbecker J, Reinbott A, Mtimuni B, et al. (2017). Nutrition education improves dietary diversity of children 6-23 months at community-level: Results from a cluster randomized controlled trial in Malawi. *PLoS One; 12*(4): e0175216. DOI:10.1371/journal.pone.0175216

20. UNICEF/WHO/World Bank. (2020). Joint child malnutrition estimates (global and regional). Available from https://data.unicef.org/topic/nutrition/malnutrition/

21. UNICEF. (2019). The State of the World's Children 2019. Children, Food and Nutrition: Growing well in a changing world: East and Southern Africa. UNICEF, New York. https://www.unicef.org/media/60831/file/SOWC-2019-ESA.pdf

22. UNICEF. (2018). Food Systems for Children and Adolescents: Working Together to Secure Nutritious Diets. Interim Summary Report. UNICEF Office of Research Innocenti, November 5-7, 2018.

23. Purwaningrum DN, Helda Yessy MS, Arcot J, et al. (2018). Validation of a measurement instrument for parental child feeding in a low and middle-income country. *International Journal of Behavioural Nutrition and Physical Activity*; 15. DOI:10.1186/s12966-018-0736-7

24. Mozaffarian D, Rosenberg I, Uauy R. (2018). History of modern nutrition science—implications for current research, dietary guidelines, and food policy. *BMJ; 361* doi: https://doi.org/10.1136/bmj.k2392

25. SADC (2018). SADC selected economic and social indicators. Available from file:///C:/Users/tturk/Documents/projects/SADC/reference/SADC_Selected_Indicators_2018.pdf

26. Kamwendo G. (2009). The SADC protocol on education and training: Linguistic implications and complications. *Language Matters. 40*(1):4-17.

27. UNESCO. (2012). SADC Education for all (EFA) Profile. Regional Bureau for Education in Africa. Available from http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Dakar/pdf/RECProfileSADC_ENG.pdf

28. Arndt C, Roberts SJ. (2018). Key issues in regional growth and integration in Southern Africa. Development Southern Africa. 35(3): 297-314.

29. World Bank. (2020). World Bank list of lower to middle income countries. Available from https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

30. GAIN/UNICEF. (2019). *Comprehensive Nutrient Gap Assessment (Conga) Findings for Children 6–23 Months In: South Africa, Ethiopia, Mozambique*. Geneva: GAIN.

31. USAID. (2020). *Factors That Influence Multi-Sectoral Nutrition Behaviours*. USAID Factsheet.

32. USAID. (2020). *Behaviours to Improve Nutrition*. USAID Factsheet.

33. Ministry of Health Tanzania. (2013). Infant and Young Child Feeding Guidelines. Republic of Tanzania. Tanzania Food and Nutrition Centre. Dar-es-Salaam.

34. FAO. (2020). Impact of COVID-19 on people's livelihoods, their health and our food systems. Available from https://www.developmentaid.org/#!/news-stream/post/76358/impact-of-covid-19-on-peoples-livelihoods-their-health-and-our-food-systems?utm_source=Newsletter&utm_medium=Email&utm_campaign=NewsAlert&token=d905ba99-06e8-11ea-8cc5-52540068df95

35. SADC. (2020). Synthesis Report on the state of food and nutrition security and vulnerability in Southern Africa. Available from https://www.sadc.int/files/7315/6284/6868/SADC_2019_Synthesis_Report_on_the_State_of_Food_and_Nutrition_Security_and_Vulnerability_in_Southern_Africa.pdf

36. Hansen YI. (2014). TV: Top 10 most-expensive programmes on South African TV. Nielsen Ad Dynamix. Available from http://www.marklives.com/2014/10/thinking-tv-top-10-most-expensive-programmes-on-south-african-tv/

37. Thomas D. (2019). Switched on: Africa's broadcasting revolution. African Business. Available from https://africanbusinessmagazine.com/sectors/business/switched-on-africas-broadcasting-revolution/

38. Alliance for Affordable internet. (2018). New data: What's the price of 1GB of mobile broadband across LMICs? Available from https://a4ai.org/new-mobile-broadband-pricing-data-2018

39. Turk T, Zaheer S, Choudhury SR, Islam MS. (2020). Developing a predictive tobacco control mass media

programming model to achieve best buys in low –and middle-income country settings. Journal of Social Marketing. (under review).

40. The Broadcast Research Council of South Africa. (2020). Broadcast Audience Measurement Update. Available from https://brcsa.org.za/

41. Angus-Hammond M. (2020). Advertising Effectiveness Evaluation: The Roles of Audience Measurement and Attribution Research. Available from https://www.geopoll.com/blog/advertising-attribution-africa/

42. Kantar Media. (2015). Africa, Second by Second. Available from https://www.kantarmedia.com/global/thinking-and-resources/latest-thinking/africa-second-by-second

43. United Nations Children's Fund (UNICEF). (2020). Improving Young Children's Diets During the Complementary Feeding Period. UNICEF Programming Guidance. New York: UNICEF.

44. SPRING. (2015). A Systems Thinking and Action for Nutrition: A Working Paper. Arlington, VA: USAID/ Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) Project.

45. Kaput J, van Ommen B, Kremer B, Priami C, Monteiro JP, et al. (2014). Consensus statement understanding health and malnutrition through a systems approach: the ENOUGH program for early life. *Genes Nutr 9:* 378. https://doi.org/10.1007/s12263-013-0378-y

46. Allender S, Millar L, Hovmand P, Bell C, et al. (2016). Whole of Systems Trial of Prevention Strategies for Childhood Obesity: WHO STOPS Childhood Obesity *Int. J. Environ. Res. Public Health, 13:* 1143. https://worldbankgroup-my.sharepoint.com/:b:/r/personal/sosornprasop_worldbank_org/Documents/Tonga%20NCD%20Taxation/SBCC%20Background%20Documents/Deakin/ijerph-13-01143.pdf?csf=1&e=cEnNih

47. Owen B, Brown AD, Kuhlberg J, Millar J, et al. (2016). Understanding a successful obesity prevention initiative in children under 5 from a systems perspective. *PLoS ONE, 13*(3):e0195141

48. Allender S, Brown AD, Bolton KA, Fraser P, Lowe J, Hovmand. (2019). Translating systems thinking into practice for community action on childhood obesity. *Obesity Review*, *20*(S2): 179-184.

49. Boer H, Seydel ER. (1996). Protection motivation theory. In M. Conner & P. Norman (Eds.). *Predicting health behaviour.* (pp. 95-120). Buckingham: Open University Press.

50. Bandura, A. (2001). Social cognitive theory of mass communication. In J. Bryant, & D. Zillman (Eds.). *Media effects: Advances in theory and research* (2nd ed., pp.121-153). Hillsdale, NJ: Lawrence Erlbaum.

51. Bandura A. (2004). Social Cognitive Theory for Personal and Social Change by Enabling Media. In A. Singhal, M. J. Cody, E. M. Rogers, & M. Sabido (Eds.), EA's communication series. Entertainment-education and social change: History, research, and practice (p. 75–96). Lawrence Erlbaum Associates.

52. West R, Michie S. (2020). A brief introduction to the COM-B Model of behaviour and the PRIME Theory of motivation. Available from https://www.qeios.com/read/WW04E6.2

53. Bandura A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. Psychological Review, 84, 191-215.

54. Ajzen I. (1991). The theory of planned behaviour. Organizational Behaviour and Human Decision Processes. 50 (2): 179–211.

55. Rogers EM. (1983). *Diffusion of Innovations.* (5th Ed.), New York: Free Press.

56. Prochaska JO, DiClemente CC. (1992). Stages of Change in the modification of problem behaviours. In M. Hersen, R.M. Eisler, & P.M. Miller (Eds.). *Progress in behaviour modification*, (pp.183-218.). New York: Academic Press.

57. Robinson T. (2008). Applying the Socio-ecological Model to Improving Fruit and Vegetable Intake Among Low-Income African Americans. J Community Health; 33:395–406

58. Sunstein C, Thaler R. (2008). Nudge: Improving Decisions about Health, Wealth, and Happiness. Yale University Press: pp312.

59. Bettinghaus EP. (1986). Health promotion and the knowledge-attitude-behaviour continuum. Available from https://www.sciencedirect.com/science/article/abs/pii/0091743586900253

60. Johns Hopkins Bloomberg School of Public Health Center for Communication Programs. (2014). The P process: five steps to strategic communication. Health Communication Capacity Collaborative. Available from http://www.thehealthcompass.org/sbcc-tools/p-process-0.

61. SADC. (2015). Implementation Mechanisms: Food and Nutrition Security Strategy 2015 – 2025. Available from https://www.nepad.org/publication/sadc-food-and-nutrition-security-strategy-2015-2025#:~:text=(iv)%20Ensuring%20stable%20and%20sustainable,access%20and%20utilisation%20of%20food.&text=The%20implementation%20of%20the%20Strategy%20will%20require%20resources%20in%20the,material%2C%20technical%20and%20financial%20resources.

62. National Food and Nutrition Commission of Zambia. (2011). National Food and Nutrition Strategic Plan For Zambia 2011-2015. Available from file:///C:/Users/tturk/Downloads/National%20Food%20and%20Nutrition%20Strategic%20Plan%202011-2015.pdf

63. Tanzania Food and Nutrition Centre/UNICEF/WHO. (2013). Infant and Young Child Feeding National Guidelines. Available from https://www.tfnc.go.tz/uploads/publications/sw1514892995-GUIDELINE%20-IYCF%202013.pdf

64 USAID. (2015). The Behaviour Change Framework: A template for accelerating the impact of behaviour change in USAID-supported MCH programs in 24 priority countries. Available from https://www.usaid.gov/sites/default/files/documents/1864/The-Behaviour-Change-Framework.pdf

65. WHO (2011). From Burden to "Best Buys": Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries. World Economic Forum; Cologny/Geneva Switzerland.