SBC Best Practices

Key Learnings from the Multisectoral Social and Behaviour Change (SBC) Programming of ADRA Yemen

ABOUT

This report was prepared as part of the Yemen Emergency Multisectoral and Lifesaving Interventions (YEMLI) project that is implemented by ADRA Yemen, funded by the USAID Bureau for Humanitarian Assistance (BHA), and technically supported by ADRA International. The report aims to share the key best practices and lessons learned from ADRA's three years of implementing a multi-sectoral SBC approach to protecting people's health and nutritional status with aid agencies and donors. In doing so, it hopes to enable other agencies to replicate some of the presented best practices, helping them to further increase the impact of their life-saving work.

Whenever this report talks about ADRA, it refers to the work done by the people who worked on implementing the YEMLI project and the previous MANR and MANR II projects. This includes both the staff of ADRA Yemen and ADRA International.

The report was published in July 2023 by ADRA Yemen, with the financial support of the USAID Bureau for Humanitarian Assistance. It is available in English and Arabic. It was written by Petr Schmied (SBC Advisor for ADRA Yemen) with the support of Ragheb Fadhl (SBC Coordinator for ADRA Yemen). It benefited from the inputs and feedback provided by the community volunteers, health facility staff, as well as the staff of ADRA Yemen and ADRA International. The cover photo shows a community SBC session. All photos used in this report were taken by ADRA staff.

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CONTENTS

ABBREVIATIONS

ADRA	Adventist Development and Relief Agency
BHA	Bureau for Humanitarian Assistance
CHNVs	Community Health and Nutrition Volunteers
KAP	Knowledge, Attitudes, and Practices
MANR	Multisectoral Assistance and Nutrition Response
SBC	Social and Behaviour Change
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene
YEMLI	Yemen Emergency Multisectoral and Lifesaving Interventions

BACKGROUND

After eight years of war and a failing economy, the humanitarian crisis in Yemen remains among the worst emergencies in the world. According to the 2023 Humanitarian Response Plan, more than 80 percent of the country's population struggles to access food, safe drinking water, and adequate health services. The prevalence of acute malnutrition is high among children.

To address the dire health conditions and alleviate the underlying food security issues, ADRA Yemen has implemented the multi-sectoral YEMLI project. Its social and behaviour change (SBC) component focused on increasing the proportion of people who adopt the promoted high-impact behaviours relating to health and nutrition, such as exclusive breastfeeding, feeding diverse meals to children, and various practices related to preventing and treating diarrhea and other infectious diseases.

Among the main SBC activities at the community level were household visits, group sessions with men and women, individual counselling, and the use of thematic videos in health facilities. ADRA's work had a strong emphasis on increasing the SBC capacities of the 'agents of change' – the people who are responsible for helping people adopt the promoted behaviours, such as community health and nutrition volunteers (CHNVs), community midwives, and health facility staff. Such 'soft' support was complemented by humanitarian distributions of cash (for improved nutrition), hygiene items, and other assistance targeting the most vulnerable populations.

Increased adoption of promoted behaviours is crucial to protect children and adults' health.

Key Terms Explained

Social and behaviour change (SBC) is a systematic process that intentionally aims to enable people to adopt and sustain positive practices and social norms.

Barriers are factors that prevent people from adopting a given behaviour, such as lack of resources, low self-confidence, or disagreement of a household member.

Enablers / motivators are the factors that help and motivate people to adopt a given behaviour, such as encouragement of household members or having the required skills.

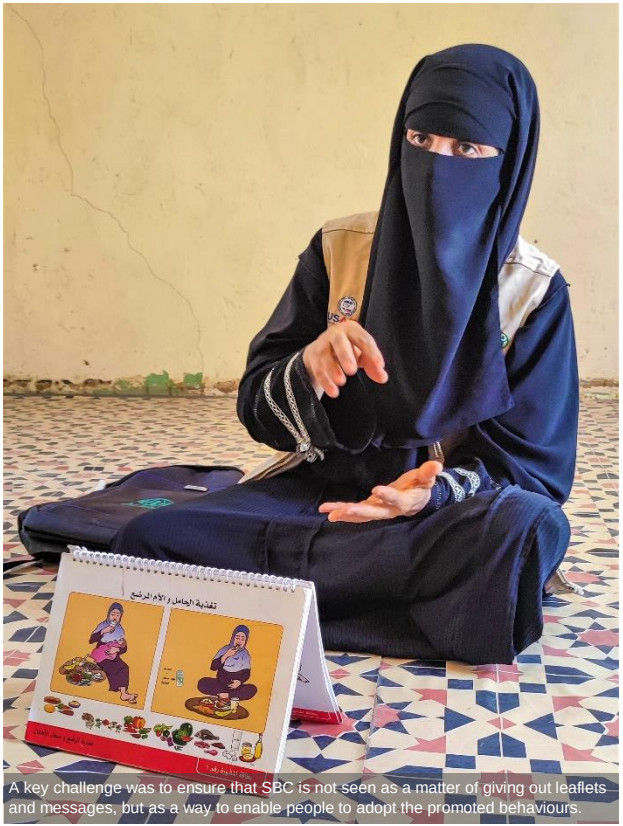
THE SBC CHALLENGE

Globally, there is a large gap between what is considered as 'SBC best practice' and the 'real SBC practice'. Over the past years, the number of resources and events providing guidance on how to effectively promote various behaviours has increased significantly. However, only a fraction of this expertise has trickled down to those who actually support and encourage people to adopt the promoted behaviours, such as community volunteers and the health facility staff. As a result, there is a **large difference between how much SBC expertise is available and how much is actually used** by the grassroots actors who are most in touch with the targeted populations.

Traditional, education-based approaches to SBC are still present, based on the misconceived belief that *"the best way to change people's behaviours is to educate them"*. This manifests in the relatively widespread use of 'awareness raising sessions' and other top-down events whose content is based on someone giving a lecture on why people should adopt the promoted behaviours. This is especially common in humanitarian contexts where the primary focus is on delivering things. Therefore, **SBC is often conceived as a matter of delivering leaflets and messages** instead of helping people overcome the barriers to adopting the promoted behaviours and offering the right motivators. Such a delivery-based approach is also common because it is easier to implement.

There are two main consequences of insufficient SBC capacities among people who do the actual SBC work at the grassroots level. First, the impact of their work is much lower than it could be. Second, the target population members lose interest in joining SBC activities, simply because they do not find them interesting and helpful.

That is why **the core of ADRA's SBC work** lies in ensuring that the people who promote various behaviours have the knowledge, skills, and attitudes required for doing their SBC work effectively.



A key challenge was to ensure that SBC is not seen as a matter of giving out leaflets and messages, but as a way to enable people to adopt the promoted behaviours.

HOW ADRA RESPONDS

In 2020, ADRA created a multi-sectoral SBC team that works in collaboration with health, nutrition, and WASH colleagues on supporting the CHNVs, community midwives, and health facility staff in the effective promotion of the prioritized behaviours relating to the three sectors. This approach is more efficient, as it reduces the need for each sectoral team to have its own SBC activities and ensures better coordination.

Over the past years, the SBC team members realized that if they want their work to be effective, they need to **focus on the quality of the work done by CHNVs** and other 'agents of change'. Practically, this means looking at:

1) *What is promoted:* The question of what CHNVs talk about with the targeted women and men has a crucial impact on the effectiveness of their work. The more relevant it is to what people want and need, the more likely it is their work will lead to the desired change.
2) *How it is promoted:* Ensuring that the priority behaviours are promoted in a way that motivates and enables people to adopt them is another pre-condition for its effectiveness.
3) *Amongst whom it is promoted:* Focusing on people who are supposed to practice the prioritized behaviours is not enough. Therefore, engaging those who influence whether the behaviours are adopted is the last key focus of ADRA's SBC work.

The following pages show how ADRA ensures that CHNVs (and other 'agents of change') **communicate about the most relevant things, in an effective manner, and with the right people.**

Interpersonal communication is the cornerstone of ADRA's SBC work.

ADRA focuses on ensuring that CHNVs and other agents of change have the knowledge and skills required to promote behaviours in engaging and effective manner.

Focusing on #1: What Is Promoted

The first aspect of ensuring the quality and effectiveness of CHNVs' work concerns what they focus on. Over the past years, ADRA has used the following best practices:

1. Prioritizing a Limited Number of Behaviours

There are dozens, if not hundreds, of behaviours that contribute to improved health and well-being. However, as we all know from our own lives, sometimes adopting even just one new behaviour is not easy. Therefore, ADRA focuses on promoting a limited number of feasible behaviours that are likely to bring the biggest benefits, due to their proven effectiveness and due to the fact that many people have not adopted them yet. Such a prioritization means that the targeted women and men are not overwhelmed by what they are encouraged to do and allows ADRA to ensure that CHNVs are able to promote these behaviours well.

2. Measuring the Prevalence of Key Enablers and Barriers

While some organizations conduct qualitative formative research identifying enablers and barriers to adopting the desired behaviours, not many also measure how prevalent these factors are. This can result in a situation where qualitative research tells us that there is a barrier, such as a certain belief, but we do not know how prevalent it is. Is it something only a few people believe in (and is therefore not worth our attention) or is it much more widespread? Therefore, ADRA conducts an annual quantitative SBC survey identifying the proportion of target group members who experience a given barrier or enabler. For example, the proportion of people who hold a certain perception / lack a given resource / have a required knowledge or skill / or experience discouragement from a family member. The surveys go well beyond the focus of the usual KAP surveys, as they cover a much wider range of barriers and enablers.

Example of Measuring the Prevalence of Enablers and Barriers

ADRA's SBC survey measured the prevalence of enablers and barriers identified by the qualitative research. In the case of exclusive breastfeeding, it measured the proportion of women who:

- think that feeding only breastmilk to children younger than six months is enough (including why some women do not think so)
- think that breastmilk formula is more nutritious than breastmilk
- were encouraged or discouraged to feed only breastmilk in the first six months of a child's life
- know how to address the most common breastfeeding difficulties

Additionally, the survey assessed who women go to for help in addressing breastfeeding difficulties as well as the perceived difficulty in accessing competent breastfeeding counselling.

General guidance on measuring the prevalence of enablers and barriers is available on the IndiKit website.

3. Focusing on Tackling the Most Prevalent Barriers

The results of the SBC surveys enable ADRA to ensure that the CHNVs focus on tackling those barriers that most people experience. This way, instead of doing a general awareness raising on the importance of behaviour and its benefits, the CHNVs can help people overcome the actual difficulties that prevent them from adopting the given behaviour. This is a key difference that significantly increases the relevance and impact of CHNVs' work. For example, instead of only talking about the importance of exclusive breastfeeding, CHNVs:

- tackle the perception that breastmilk alone is not enough
- talk with household members who are not supportive of feeding only breastmilk
- help women overcome any breastfeeding difficulties they face
- ask women who fed only breastmilk to share their experience

Focusing on #2: How It Is Promoted

The major focus of ADRA's SBC work is on ensuring that CHNVs (and other 'agents of change') have the knowledge, skills, and attitudes required to promote the prioritized behaviours in a way that motivates and enables people to adopt them. This has involved the following best practices:

1. Starting with ADRA Staff

One of the main obstacles to more effective SBC work is the deeply held beliefs of some aid agency staff about what SBC is actually about. Therefore, the first step was to ensure that ADRA staff understand that SBC should not be about handing out leaflets and imparting messages but about understanding people's perspectives and experiences and using this to help them adopt the promoted behaviours. This has been a longer-term process involving sharing what does (not) work, discussions, scenarios, as well as reflections on people's personal experiences with changing their own behaviours.

2. Identifying Key Gaps & Strengths in CHNVs' SBC Capacities

The next step was to understand what the key strengths and weaknesses are in how CHNVs promote the prioritized behaviours. ADRA defined which SBC competencies CHNVs need to do their community SBC work effectively, such as active listening, facilitating discussions, verifying people's understanding of what was shared, and using the Negotiated Behaviour Change approach. ADRA then conducted observations of home visits and group sessions to identify the extent to which CHNVs use these competencies. This helped ADRA understand what needs to improve and what existing positive practices should be appreciated and promoted further.

3. Adapting the 'Make Me A Change Agent' Training Module

To address the gaps in CHNVs' SBC competencies, ADRA simplified the USAID-funded Make Me a Change Agent training module and adjusted it to the local context. The training guidance became shorter which made it easier for the team of Yemeni trainers to deliver the training and for the participants to comprehend its content. It was adjusted to give the most attention to the key weaknesses identified when observing CHNVs' work, such as limited use of discussion, not asking enough about people's experiences and opinions, insufficient use of existing good practices used by some of the targeted women and men, and not verifying whether people understand what the CHNVs shared with them. The participatory design of the training enabled CHNVs to practice what they have learned while sharing their own good practices with others. All CHNVs collaborating with ADRA have completed the training.

4. Ensuring that CHNVs Have the Required Technical Capacities

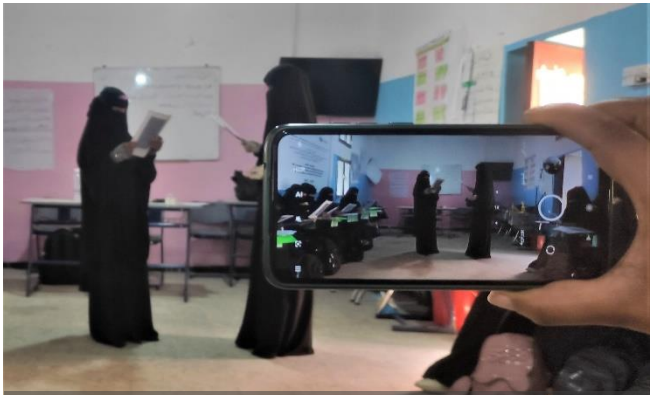
In order for CHNVs to be respected by the community members and for their support to be useful, they must have a good technical understanding of the promoted behaviours. They also need to have the knowledge and skills required for helping people overcome the various barriers to adopting these behaviors (e.g., how to overcome specific breastfeeding difficulties or how to ensure nutritional meals when the resources are scarce). Therefore, all CHNVs received a two-day technical training provided by ADRA's health, nutrition, and WASH staff, covering the promoted behaviours and how to help people address the most common barriers to adopting the behaviours.

5. Using a 'High-Frequency, Low-Density' Follow-up Approach

ADRA's support to CHNVs is based on the 'high-frequency, low-density' approach to learning. It recognizes that if we want CHNVs to improve their SBC competencies, we cannot rely on one-off training. Anyone who has attended a learning event knows that after some time, we only remember a fraction of what was shared with us. Therefore, it is crucial that any capacity-building initiatives are a long-term effort that is based on enabling people to frequently learn smaller volumes of information and skills that they can digest and remember. In the case of ADRA's SBC work, this is done through:

- Organizing **monthly or bi-monthly meetings** with CHNVs at the local health facility where they can share their recent experience, discuss how to overcome any challenges they face, learn new things, and prepare for the upcoming work. The meetings are led by the local health facility staff following the standard operating procedures that were developed by ADRA.
- Providing and discussing with CHNVs the **two-page guidance** on each of the promoted behaviours that explains its importance, what the most common enablers and barriers are, how can CHNVs help with addressing the barriers, and what messages they should use. The two-pagers serve as reminders of what was discussed during the (bi)monthly meetings. Their content is updated based on the results of the conducted SBC surveys.
- Supervising CHNVs' work (home visits and group sessions) by using **observations-based electronic checklists** that monitor the extent to which they use the recommended SBC practices. The data enables ADRA to focus on the persistent weaknesses and to understand the effectiveness of its capacity-building support. For example, the percentage of CHNVs who follow the desired practices has increased from 43% to 88%.
- Offering **WhatsApp-based support** to CHNVs – sharing useful information via text and voice messages and videos, letting CHNVs share their experience in a dedicated WhatsApp group, and encouraging them to contact ADRA in case they need help.

The starting point for ADRA's SBC capacity-building work was to ensure that ADRA staff has a good understanding of what effective SBC is about.


ADRA's SBC capacity-building activities use the principles of adult learning that build on people's strengths, help them realize any weaknesses, and provide ample time for practice.

6. Decreasing Reliance on ADRA

In the past two years, ADRA paid more emphasis on ensuring that CHNVs are supported primarily by the staff of the local health facilities as opposed to by ADRA staff. This was crucial for ensuring that at least some of the SBC support will continue even when ADRA's assistance has come to an end. This means shifting from supporting CHNVs directly to helping the health staff support CHNVs as a part of their regular work. This involved, for example, providing workshops on SBC skills and supporting the staff in leading regular meetings with CHNVs.

7. Using Data to Decide on the Communication Channels

Another good practice relates to how ADRA decides on which communication channels will be used to promote the prioritized behaviours. As there are dozens of possible channels, ADRA wanted to prioritize those that are known to be effective (e.g. interpersonal communication), are feasible, and can reach the targeted women and men who belong to the most vulnerable members of the population. To do so, ADRA used its quantitative SBC survey to collect information on people's literacy, which sources of health-related information they trust the most, and which channels they use (e.g. how many use a phone, social media, or radio). This data helped ADRA understand which channels are most likely to contribute to the higher effectiveness of its SBC work. For example:

- 29.9% of the women targeted by the YEMLI project were not able to read which meant that the use of written materials would not be appropriate
- only 7.3% of women were using radio and 22.5% were using mobile phones connected to the Internet which limited the use of radio and online communication
- on the other hand, most CHNVs had smartphones and connected to the Internet frequently which allowed ADRA to provide capacity-building support online and to use videos during household visits
- 89.9% of the targeted women knew a CHNV living in their village

Ensuring that health facility staff is motivated and able to support CHNVs' SBC work was key to its long-term continuation.

ADRA's SBC surveys have provided valuable data on which communication channels to use.

Focusing on #3: Amongst Whom It Is Promoted

The last key aspect of how ADRA tries to ensure the maximum impact of its SBC work concerns its target groups. The good practices include:

1. Engaging the Influencers

ADRA's formative research showed that whether a behaviour is adopted or not depends not only on the person who is supposed to practice the behavior but also on other people, the so-called influencers. These can be, for example, mothers-in-law who influence whether infants are breastfed exclusively or husbands who influence the availability of soap. Without engaging these people in the promotion of priority behaviours, the success of ADRA's SBC efforts would be more limited. The influencers are engaged primarily during household visits but in 2023, ADRA started organizing dedicated sessions for men. This wasn't easy, as CHNVs are female, and due to cultural reasons, most cannot engage with groups of men. In the absence of male CHNVs, ADRA had to pilot alternative solutions, such as supporting health facility staff in organizing SBC sessions for men.

2. Tailoring the Communicated Content

It is important that the content of SBC communication is adjusted to what the influencers should know and do, as this is often different from what is communicated to the people who should adopt the given behaviour. For example, while men do not need to know how to overcome breastfeeding difficulties, they must understand that exclusive breastfeeding can be time-consuming and that women might need extra help during this period. Therefore, ADRA has worked on preparing dedicated SBC sessions for men whose content is tailored to the role that men play in enabling women to practice the promoted behaviours.

3. Building on Existing Communication Channels

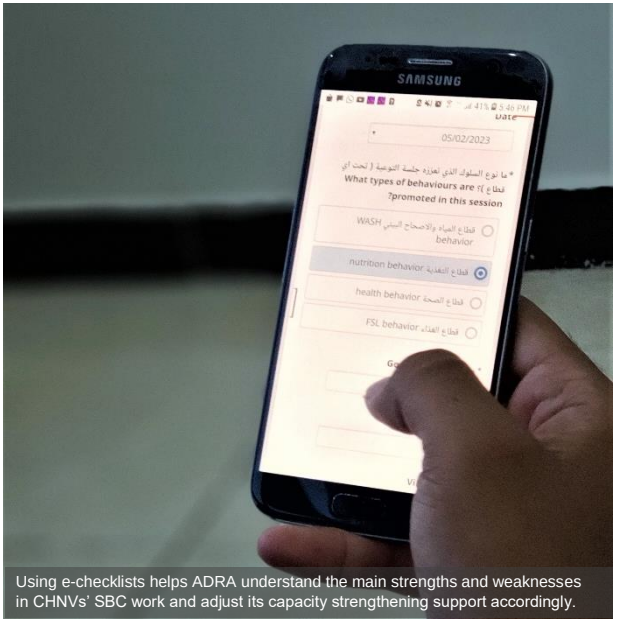
Yemen is a conservative context and some men might not like the idea of attending official health or nutrition sessions – i.e., something that is often perceived as women's responsibility. Therefore, instead of asking men to come to any SBC events, ADRA tries to meet them at places where they naturally socialize. Many Yemeni men meet frequently to chat and chew khat. Meeting them in the earlier parts of the day gives an opportunity to discuss with them health and nutrition topics in a context they are comfortable in.

Men's attitudes and practices can serve both as significant enablers as well as barriers to the adoption of promoted behaviours. That is why ADRA has increased their involvement.

KEY LESSONS LEARNED

The continuous process of improving the quality, relevance, and impact of ADRA's SBC work has generated multiple lessons learned, including those we share with you below:

- The last annual SBC survey showed that **ADRA's SBC work has very good results** – fewer people are experiencing the main barriers and more people have adopted the promoted behaviours. For example, the proportion of women who breastfed their newborns in the first hour after birth has increased from 43% to 78.9%. The proportion of women who consumed at least five food groups during the previous day or night has increased from 5.2% to 15.7%. In the absence of a control group, we cannot prove that this is due to ADRA's systematic focus on the quality of CHNVs' work but there is a high likelihood that more competent and motivated CHNVs result in better outcomes.
- **Measuring the prevalence of barriers** and focusing on the most prevalent ones has been the cornerstone of ADRA's SBC work. It enabled ADRA to move away from general awareness raising and education and focus on the real reasons why some people do not adopt the promoted behaviours.
- The **'low-density, high-frequency' approach** to learning is effective not only in increasing CHNVs' SBC skills but also their motivation, as they value having someone meet them regularly, appreciate what they do well, and help them to keep learning.
- The **simplification of the Make Me a Change Agent training** module was crucial for its uptake, as it was then much easier for the trainers to deliver good quality training.
- The community members appreciate **the discussion-based approach used by CHNVs**, as it is more engaging and shows interest in what they think and experience. It increases their motivation to participate in further SBC activities.
- The **e-checklists provide a real-time understanding** of the quality of CHNVs' work and enable ADRA to focus on the key gaps.
- Last, there is a perception that in humanitarian contexts there is not enough time for quality SBC work. However, **since many emergencies are protracted crises, usually there is enough time to do SBC well**. The key is to change the way aid workers think about SBC and to take advantage of the wealth of good SBC practices generated by more progressive interventions.



Using e-checklists helps ADRA understand the main strengths and weaknesses in CHNVs' SBC work and adjust its capacity strengthening support accordingly.

WHAT WE OFFER YOU

In addition to the experience shared in this report, you can also take advantage of the resources that we developed to maximize the impact of our SBC work. Contact us in case you are interested in exploring any of the following resources:

- Electronic checklists that we use to monitor the quality of CHNVs' home visits and group sessions.
- Two-pagers providing CHNVs with guidance on how to promote priority behaviours.
- Standard Operating Procedures for monthly workshops with CHNVs.
- Standard Operating Procedures for multi-sectoral SBC work.
- SBC survey questionnaires and reports.
- Simplified Make Me a Change Agent training module.
- Selection of videos used by the CHNVs.
- We are also open to discussing our practical experience with you – feel free to get in touch.

At the same time, we are keen to learn from your SBC experience. Please **share with us any lessons and good practices** that might be relevant to our SBC work.

ADRA's SBC team.

GET IN TOUCH

Would you like to learn more about our best practices or share your experience with us? Feel free to contact us.

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Learn more about ADRA's work at www.adra.org.