An Integrated Social and Behavior Change (SBC) Strategy to Engage and Support Adult Audiences to Take Action for their Health and Wellbeing

Revised: June 2020

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We are also highly appreciative of the contributions and participation that was accorded during the development of this strategy by other key public health stakeholders and implementing partners. These collaborative efforts helped to ensure that the social and behavior change (SBC) priorities, approaches, and activities proposed under this strategy are not only aligned to, and contributing to, the GOT's national strategic health priorities, but also complement and enhance other IPs' activities, to maximize and avoid duplicative SBCC efforts.

USAID Tulonge Afya would also like to express its gratitude for financial support and technical direction provided by USAID.

Contents

Acronyms

ACT	Artemisinin Combination Therapy
ADDED	Audience-driven Demand, Design, and Delivery
ANC	Antenatal Care
ART	Antiretroviral Therapy
BF	Breastfeeding
CBO	Community-based Organization
CHW	Community Health Worker
DHS	Demographic and Health Survey
EBF	Exclusive Breastfeeding
EVD	Ebola Virus Disease
FGD	Focus Group Discussion
FHI 360	Family Health International
FP	Family Planning
GOT	Government of Tanzania
HCD	Human-Centered Design
HIV	Human Immunodeficiency Virus
HPS	Health Promotion Section
HTC	HIV Testing and Counseling
IPs	Implementing Partners
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment in Pregnancy
ITN	Insecticide-treated Net
LTFU	Loss to Follow Up
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCM	Modern Contraceptive Method
MNCH	Maternal, Newborn, and Child Health
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
NACP	National AIDS Control Programme
NMCP	National Malaria Control Programme
NTLP	National Tuberculosis and Leprosy Programme
ORS	Oral Rehydration Solution
PBC	Provider Behavior Change
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Post Natal Care
PORALG	President's Office – Regional Administration and Local Government
PPFP	Post-partum Family Planning
PrEP	Pre-exposure Prophylaxis
RCHS	Reproductive and Child Health Services
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SBC	Social and Behavior Change

SBCC	Social and Behavior Change Communication
SMS	Short Message Service
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TBC	Tanzania Broadcasting Corporation
TCRA	Tanzania Communications Regulatory Authority
TDHS	Tanzania Demographic and Health Survey
THIS	Tanzania HIV Impact Survey
TV	Television
USAID	United States Agency for International Development
USG	United States Government

Introduction and Background

The Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC), through the Health Promotion Section (HPS), with technical support from the United States Agency for International Development (USAID)-funded Tulonge Afya project, and in collaboration with stakeholders, has developed an integrated social and behavior change (SBC) strategy to improve adoption and maintenance of healthy behaviors. This strategy focuses on key behaviors prioritized by the MOHCDGEC related to Human Immunodeficiency Virus (HIV), malaria, family planning and reproductive health (FP/RH), maternal, newborn, and child health (MNCH), and tuberculosis (TB) among adult audience segments. It may also enable integration of activities to address emerging infectious diseases, such as Ebola virus disease (EVD) and COVID-19, as appropriate.

The Adult Strategy seeks to transform implementation of health SBCC from a vertical approach, to one that is integrated across health areas, levels, and where possible, sectors. A common brand for this 'Adult Platform', NAWEZA, has been developed to bring together the focal health areas in an integrated fashion across two primary SBC packages – 1) Pregnancy and Childbirth and 2) Caregiving of <5 Children. The Adult Platform umbrella brand will grow brand equity, build trust over time with key audience segments, and allow for the delivery of mutually reinforcing activities and messages using a phased implementation approach. Most adults 18-49 (and older for TB) in Tanzania will be targeted through at least one of the NAWEZA packages or health area-specific campaigns. Many adults will be targeted by more than one package or campaign over the life of the project.

The 'Adult Platform' will reinforce the Government of Tanzania's (GOT) 'Youth Platform[i]' to ensure complementarity and linkages across the areas of relationships, and where youth aged 18-24 are married or partnered with children or planning families. This will be achieved through use of reinforcing messaging that cut across both platforms and integrated activities where youth enter the life stages of Pregnancy and Childbirth and Caregiving of <5 Children.

Towards the development of this strategy, the HPS of the MOHCDGEC with stakeholders held a three-day design workshop from July 2-4, 2018. The ideas and recommendations from the workshop are reflected in this document. Towards the strategy's implementation, the MOHCDGEC, with assistance from USAID Tulonge Afya, works with a range of implementing partners (IPs) to build capacity on its use and implementation. It develops implementation support tools and standard operating procedures that include supportive supervision and quality assurance processes and metrics to support high quality implementation and fidelity to the strategic approach outlined in this document.

Finally, SBC cannot be static and is ever-evolving. Monitoring and evaluation (M&E) for real time adjustment of SBC programs will be an important component of this strategy. Annually, the strategy will undergo review and will be updated to reflect lessons learned from its implementation and to address emerging SBC needs. This 2020 strategy update seeks to adjust behavioral and communication objectives to address emerging needs and lessons learned from

[i] Also supported through the USAID Tulonge Afya project.

USAID Tulonge Afya's first year of NAWEZA implementation. It further places a heavier emphasis on social and gender norms, FP/RH, and addressing issues related to provider behavior change (PBC). Future updates to this strategy will continue to be data-informed and driven by implementation experience and/or to address emerging needs (e.g., COVID-19).

Approach

The Adult Strategy applies an ADDED approach. ADDED stands for **A**udience-driven **D**emand, **D**esign, and **D**elivery. It is an audience-centered approach to ensure the MOHCDGEC is meeting the diverse and complex needs of individuals, communities, and the SBC systems that support them. ADDED seeks to understand what people demand – or desire – and to deliver activities that address this using a range of participatory methods. This ADDED approach is being taken to segment audiences, address behavioral determinants, and produce AND deliver solutions at individual, community, and system levels with and by our audience.

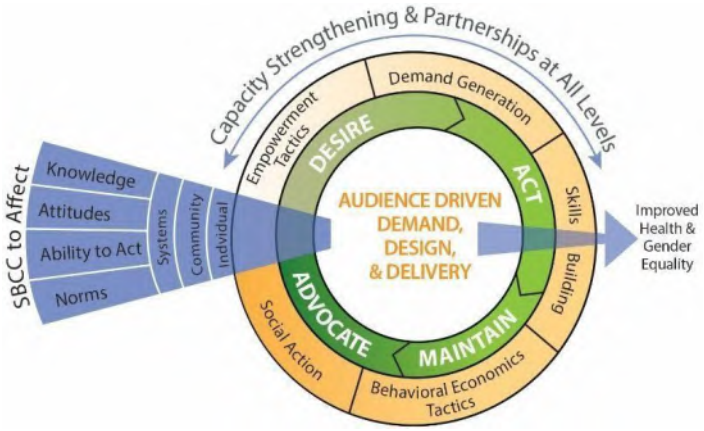


Figure 1. ADDED Theoretical Approach

ADDED utilizes a socio-ecological model to address multiple levels of influence on behavior, and applies specific SBC tactics based on where audiences fall on a spectrum of behavior change to:

- Increase desire or demand for healthy behaviors, products, and services
- Move audiences from intention-to-action
- Support behavioral maintenance
- Facilitate individual and community advocacy for change

Rationale for an Integrated Strategy

This Strategy will advance the application of integrated SBC across five focal health areas to engage with Tanzanian audiences more holistically. SBC will be targeted to audience segments, honoring the fact that people have different health issues, life priorities, and needs.

A Life Stage approach is being used as a framework for this integration and to address complementary behaviors through several SBC packages – 1) Pregnancy and Childbirth and 2) Caregiving of an <5 Child. Audiences falling under other key Life Stages, such as Adolescence and Relationships are addressed through the MOHCDGEC's Youth Platform. Through this approach, audiences are engaged with the information, motivation, and skills that they need to adopt healthy behaviors relevant to their current needs, while norms are simultaneously targeted that impede adoption and sustainability of these behaviors.

The Life Stage approach draws upon psychosocial theory. It allows for a developmentally appropriate analysis of how people enact change at key times within their lives with recognition

of the health and development vulnerabilities that they face at each stage. As individuals have different health needs and priorities based on their life stage, the Life Stage SBC Packages enable tailored messages, activities, and channel selection for each key stage.

The driving force behind this integrated strategy is to have SBC organized and delivered around the audience and not a health area or disease, where it is feasible and advantageous to do so. This approach is in line with the national strategy for integrated health services, is reflected in the organization of the Sustainable Development Goals, and dovetails with the work of USAID's ongoing USAID Boresha Afya projects that are working to support the GOT to strengthen provision of integrated services. This approach also respects the complex relationship between health and illness such as HIV/TB and that people have different needs at different times of their lives, such as pregnancy.

Provider Behavior Change

Health providers are critical gatekeepers of health services, important channels of health information, and can play a key role in challenging or propagating existing social norms within their community. Health providers' behavior can also influence their clients' trust in the health system and provider-client interactions – whether positive or negative – can affect a client's likelihood to seek care in future. As initially developed, the Adult Strategy integrated health providers as audiences within each Life Stage package and campaign, with provider-focused communication objectives established in support of each of the priority behaviors. However, based on the project's implementation experience, it was determined that a more substantive focus on providers was required. Therefore, as part of updates to the Adult Strategy in FY20, a heavier PBC emphasis has been included. This includes delineation of discrete PBC objectives, and associated activities. Health providers, both facility and community-based, will be engaged with tools and activities that will promote positive practices in support of the Adult Strategy priority behaviors and broader NAWEZA aims and objectives.

Alignment with the GOT's National Health Strategic Priorities

The Adult Strategy has been developed with a strong grounding in national strategy documents and policy decisions. The following is the list of key documents used to guide the development of this strategy.

Area	Document	Priority Direction for USAID Tulonge Afya
Crosscutting	Health Sector Strategic Plan IV: 2015-2020	Strategic Direction Health Promotion: "Invest in health promotion interventions that give emphasis to multisectoral approaches in addressing the preventable causes of disease, disability, and premature deaths in all population groups throughout the course of life".
HIV/AIDS	National HIV and AIDS Advocacy and Communication Strategy: 2013-2017	Strategic Approach 2: "Build on and expand traditional and emerging advocacy and communication channels. "There is need to develop an appropriate mix of

Area	Document	Priority Direction for USAID Tulonge Afya
		communication channels, balancing mass media and interpersonal communication."
TB	Advocacy, Communication and Social Mobilization Strategy and Implementation Plan for TB and Leprosy Program: 2015-2020	Priority Activities Behavior Change Communication: • Undertake community awareness campaign and mobilization particularly household visits to counsel TB and leprosy patients on treatment adherence and completion. • Undertake community awareness campaign and mobilization to increase knowledge and awareness about recognition, symptoms, transmission and prevention of TB and leprosy, mitigate stigma associated with TB and leprosy and where TB and leprosy services are offered
Malaria	Communication Guide for Malaria Control Interventions, 2015 - 2020	Strategic Objectives: • Prevent the occurrence of severe morbidity and mortality related to malaria infection through promotion of universal access to appropriate early diagnosis and prompt treatment and provision of preventive therapies and vaccines to vulnerable groups • Create an enabling environment where individuals and household members are empowered to minimize their own malaria risk and seek proper and timely malaria-treatment when needed.
MNCH & RH	The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016 - 2020); ONE Plan II, November 2015	Key Strategy: Community mobilization and participation to improve key maternal, newborn and child care practices, generate demand for services and increase access to services within the community.

Optimizing Data and Learning to Inform Evidence-based SBC Activities

Literature reviews, a household baseline survey, and various formative research were conducted to inform the development of this strategy. Audience consultations were held to understand underlying emotional drivers that influence individual and community behaviors as people often make decisions based on emotions and the influence of social networks, rather than from a place of logic. Specifically, audience consultations were conducted to better understand factors that

drive HIV testing and antiretroviral therapy (ART) uptake; malaria, FP, MNCH, and TB priority behaviors. A Gender and Youth Assessment and a study using the Social Norms Exploration Tool was also conducted to identify norms and other factors influencing key strategy objectives. Baseline data were used to inform this strategy through analyses of 'doers' – or those who currently report successful execution of desired behaviors – and 'non-doers,' to identify key factors for prioritization. A study on loss-to-follow up (LTFU) among people living with HIV (PLHIV) also used a doer/non-doer approach to understand the barriers and facilitators to adherence and retention in HIV care and treatment.

Priority Behaviors

The following are priority behaviors covered under this Strategy by SBC package. These behaviors were selected at a prioritization workshop held with key stakeholders in October 2017 and agreed upon during the Adult Strategy Development Workshop. They were selected because of their likely effect on morbidity and mortality (e.g. alignment with Accelerator Behaviors[ii]), likeliness to affect multiple health outcomes (e.g. Gateway Behaviors[iii]), or alignment with service delivery partner, GOT, and USAID priorities. While there are a myriad of behaviors that could be targeted, the Adult Strategy is focusing on the key behaviors outlined below with the target audiences' ability to act being taken into consideration. Priority behaviors under the GOT's Furaha Yangu campaign are also included as a health area specific campaign aligned with the NAWEZA platform. As additional, health area-specific campaigns are developed and implemented under the Adult brand, this strategy will be amended to include them on an annual basis. Additional behaviors identified as key priorities in conjunction with service delivery partners, GOT, and USAID were added as part of the FY20 strategy update, and are marked with an asterisk (*). Beginning in FY20, the USAID Tulonge Afya project is also supporting uptake of pre-exposure prophylaxis (PrEP) among priority audiences in collaboration with the USAID-funded CHOICE and EpiC projects. USAID Tulonge Afya is participating in use of human-centered design (HCD) approaches to develop PrEP media and materials and will support their use by IPs through development of implementation guides and trainings. Based on insights gathered during the PrEP pilot, which indicated that including PrEP within broader HIV campaigns resulted in confusion as to the difference between PrEP and ART, it was decided that PrEP will not be nested under the Furaha Yangu campaign. PrEP messages and materials will be developed with their own look and feel, separate from NAWEZA and Furaha Yangu.

Pregnancy and Child Birth	Caregiving <5 Children	Furaha Yangu
• Go early, attend, and complete **more than** 4 antenatal care (ANC)	• Sleep under an ITN every night, including children under five	• Go for HIV testing and counseling if at risk, and receive results

[ii] An Accelerator Behavior is a behavior that is practiced by a primary actor, such as a caregiver or mother that: 1) directly or indirectly reduces the risk of MNCH morbidity or mortality due to a preventable cause and 2) has low uptake in a particular context. These are considered priority behaviors for programs to emphasize because they have the highest potential to hasten the decline of child and maternal deaths since they have relatively low uptake yet impact a major cause of child and/or maternal mortality across the continuum of care/lifecycle.

[iii] Gateway behaviors are behaviors that can facilitate/encourage/increase the potential for individuals to engage in other positive health behaviors, both simultaneously and across the lifecycle. For example, a pregnant woman attending ANC can lead to uptake of IPTp, HIV testing, facility-based delivery, and subsequent post-partum family planning (PPFP) use.

visits (8 contacts are desired) • Take intermittent preventative therapy-3 (IPTp-3) during ANC visits • Sleep under an insecticide treated net (ITN) every night, including pregnant women • Attend Prevention of Mother-to-Child Transmission (PMTCT) services and take ART as prescribed if HIV+ • Attend a health facility for delivery • Initiate breastfeeding (BF) within the first hour of birth • Talk with your health care provider about post-partum FP (PPFP) options • Attend postnatal care (PNC) visits and seek prompt and appropriate care at the health facility upon the first sight of post-partum danger signs • Bring your infant to the facility for an early visit at 4-6 weeks, and for HIV testing if mother is positive or status unknown	• After a live birth, use a modern contraceptive method (MCM) to avoid pregnancy for at least 24 months • Exclusively breastfeed (EBF) your infant for six months after birth • Seek and receive prompt and appropriate care at first sign of newborn and childhood illness • For malaria, seek and receive prompt and appropriate care at the health facility for yourself or a child under five with a high fever, including use of a rapid diagnostic test (RDT) to confirm malaria • Seek and receive a full course of timely vaccinations for infants and children under two	• If HIV positive, enroll in care, initiate ART, and follow health care worker guidance • Ask to be started on TLD when enrolling on ART* • Take ART regularly, as prescribed, and go for routine viral load monitoring • For HIV+ women, go for cervical cancer screening* • Seek care from a qualified TB provider for a cough that persists for more than two weeks

Gender Integration

The GOT has committed to mainstreaming gender throughout all health programs and to adopting a human rights approach as the basis of planning and implementation. A Gender and Youth Assessment was conducted to examine 7 key domains to ensure gender integration is nuanced and appropriate for both the Adult and Youth Platforms it is supporting. The domains included: (1) laws, policies, regulations, and institutional practices, (2) access to and control over assets and resources, (3) knowledge, beliefs, perceptions, and cultural norms, (4) patterns of power and decision-making, (5) gender roles, responsibilities, participation, and time used, (6) human dignity, safety, and wellness, and (7) social norms that influence health-care seeking and healthy behaviors. The Gender and Youth Assessment demonstrated how the low uptake of health information and services by women and youth is deeply influenced by social conditions, which have been instituted by the communities in which they live and diffused through social norms, societal expectations, and parent/child, partner, and patient/provider power dynamics. The MOHCDGEC seeks to address and alleviate harmful gender and socio-cultural norms at the individual, community, and health system levels under both the Adult and Youth Platforms.

Recommendations from the assessment relevant to the Adult Platform include ensuring that gender differentiated rights, roles, and responsibilities are accounted for in the message development process; directly addressing gender-based stigma and discrimination; and training and community dialog with community-based support systems, such as clan elders, religious leaders, and opinion leaders to deconstruct societal perceptions, norms, and patriarchal values that perpetuate risky behaviors.

Focal Norms

In addition to delineating priority behaviors that will be addressed using the Life Stage SBCC packages, the Adult Strategy will ensure a cross cutting focus on norms that drive poor health outcomes. These include: 1) prevention of violence that permeates households and communities and affects approximately 40% of women before the age of 15[1]; 2) reducing stigma and discrimination, which directly impacts quality of care and service seeking (especially for audiences, such as people living with HIV [PLHIV], unmarried pregnant women, and youth); 3) couples' decision-making and dialog; and 4) norms around masculinity, which inhibit health care seeking among men and directly affect women and children's health and wellbeing. In FY20, the Passages Project-developed Social Norms Exploration Tool (SNET) was used to further explore social norms that serve as barriers to uptake of FP/RH services. Through rapid individual interviews with married/cohabiting adults, in-laws (husband/male partner's family) and peers were identified as key reference groups for FP decisions. Subsequent focus group discussions (FGDs) with married/cohabiting adults identified key social norms that impact MCM use for child spacing. These include: 1) the expectation that married women should bear many children; 2) household decision-making, including around use of FP and family size, is the role of men and is not something discussed between couples; and 3) norms around masculinity are closely tied to family size. A greater emphasis on addressing these norms is reflected in FY20 updates to communication objectives related to FP/RH priority behaviors.

Principles of Audience Engagement

Implementation of the Adult Strategy requires implementers deeply engage audiences to identify and produce solutions to improve health behaviors, address harmful norms that drive poor health outcomes, and in delivering activities. The MOHCDGEC ensures that what audiences want, or

demand, for their lives and families is at the center of programming and that it is further co-designed and delivered (e.g., through engagement with media, social action, electing to be a change agent, etc.) with and through audiences.

Leveraging Recent and Existing Campaigns

A landscape mapping of all health campaigns for HIV, malaria, FP/RH, MNCH, and TB since 2010 was conducted. To ensure that good programming was continued and built upon, an 'Accelerated Support Strategy' was implemented from Q1-Q3 of FY2018, with a focus on extending the integrated MNCH campaign *Wazazi Nipendeni*, as well as other campaigns addressing the MOHCDGEC's priority health areas. Sets of materials and selected radio content were reviewed and repurposed until new content, under this Strategy, was phased in. As the Adult Strategy is implemented under an umbrella brand, key messages, activities, and community programming that showed success were folded under the brand to enable a comprehensive approach to reach Tanzanians within the targeted Life Stages.

As new funding becomes available for SBC programming, such as funding from the Global Fund for malaria, support will be provided to the various health technical teams at the MOHCDGEC to actively link activities to the Adult Platform brand.

There is a great complementarity and a mutually reinforcing relationship between the national Jiongeze 'Carry Them Safely' campaign, which focuses on maternal and child health issues and is successfully promoting and driving accountability and professionalism among service providers to deliver the full range of high-quality comprehensive services to women during pregnancy, child birth, and after delivery. Additionally, Jiongeze is encouraging and helping women to hold health providers accountable for delivering these core services by raising awareness among pregnant women and mothers of the services available to them while they are pregnant and for after childbirth.

NAWEZA, 'I can,' is a platform that enables messages spanning a range of health issues, including malaria, HIV, MNCH, FP, TB, and emerging infectious diseases, to be packaged to target adults in two lifecycle groups, firstly pregnancy and childbirth and secondly caregiving of children under 5 to promote individual adoption of healthy behaviors and increase service utilization. The platform can also be used to incorporate vertical, health-area specific SBC activities as needed.

Naweza is highly complementary to the Jiongeze campaign and will on all its MCH related materials carry the Jiongeze logo to reinforce the two and demonstrate the complementarity.

Communication Landscape

Regulatory Body: The Communications and Broadcasting sectors in Tanzania are monitored and regulated by the Tanzania Communications Regulatory Authority, a quasi-independent Government body. It was established under the Tanzania Communications Regulatory Act No.12 of 2003 to regulate the electronic communications, postal services, and management of the national frequency spectrum in the United Republic of Tanzania.[2]

Media Environment: Tanzania has several communication channels, some preferred over others, based on access and literacy levels of intended audiences, among other preferences. According to findings from a report developed by InterMedia in Tanzania, the most trusted sources of news and information are radio, television (TV), and the Government, followed by family and friends.

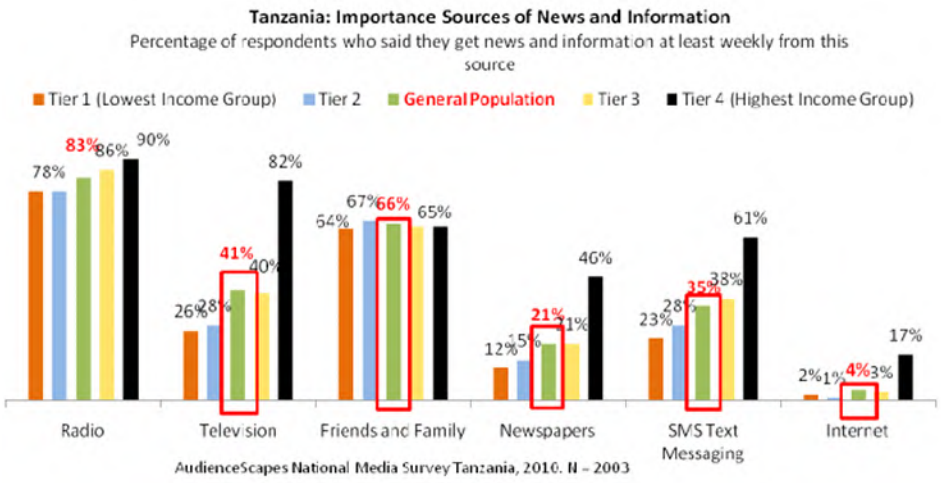
Tanzania has approximately 47 FM radio stations.[3] Eighty five percent of the general population has access to a radio according to data available at the time of drafting the original NAWEZA strategy. The average time spent listening to the radio in a given day is 93 minutes, with the morning slot (7-9 am) being the most popular.[4] Within the lowest socioeconomic bracket, 75% have access to a radio. Radio stations that have national reach are those that are state-owned by the Tanzanian Broadcasting Corporation (TBC) Taifa and TBC FM.[5] The most popular radio station in Tanzania is Clouds FM.[6] There are some private radio stations such as Radio Free Africa and Radio One that also have national reach. Eighty-three percent of Tanzanians report they get news and information from radio, making it the leader of both media and non-media sources.[7] Radio is the top source of information for every age group and income group, as well as both males and females, and rural and urban residents.[8]

Twenty-seven percent of the general population have access to a TV within their home; 13% of the lowest socioeconomic and 79% of the highest.[9] TV is the second most commonly consumed media type.[10] The three most popular channels broadcast on in Tanzania are ITV, Clouds TV, and TBC 1.[11] The average amount of time spent watching TV is 67 minutes per day with the most popular time being in the evening from 7-10 pm.[12] TV viewership is largely driven by news and current affairs.[13]

The internet is the next most commonly accessed media channel and is most often used for chatting with friends through social networks, general internet surfing, and for getting updates on the news and current affairs.[14] The most popular social networks are Facebook, WhatsApp, and Instagram. Ninety-eight percent of those surveyed who were over 15 years of age and have used the internet are a member of some social network platform.[15]

Tanzania has several mobile phone providers with the two leading providers being Tigo and Vodacom Network.[16,17] Sixty-two percent of the general population has access to a mobile phone.[18] Within the lowest socioeconomic bracket, 40% have access to a mobile phone.[19] There are 537 registered print news media outlets however, there is low newspaper readership in rural and Southern Tanzania due to low literacy levels and accessibility. Newspaper readership increases with income and urbanization.[20]

Figure 2: Sources of Information[21]



Communication Preferences: The national languages of Tanzania are English and Kiswahili, although there are approximately 120 ethnic groups within Tanzania, each with its own dialect. The language of preference for listening to on the radio is Kiswahili followed by English. Literacy levels in Tanzania are 77% for women and 83% for men.[22] Approximately half of Tanzanians have completed primary school but did not continue to secondary school.[23]

Health Information: A health facility was considered by most Tanzanians as the most important and reliable source of health information. Religious leaders and radio were ranked second and third as the best sources, respectively.[24] Health communication is disseminated at the district level through the following channels: local media, mass media, print materials and interpersonal contact, with the most commonly used channels being local and mass media. Public meetings, radio, and print materials were also used formats for health communication.[25]

Women view medical doctors, pharmacy shops, and family and friends as the principal sources for information for their health and the health of their children. Radio and TV were rated as preferred sources of information by women, whereas internet, local herb hawkers, and mobile phones were rated as non-preferable.[26] Women reported more regular opportunities to participate in health education sessions (mostly through MCH clinics) than men.[27]Men were more likely to receive health information through the radio and television.[28]

Situational Analysis

Tanzania's political stability and economic growth over the last decade has resulted in significant health improvements, including the achievement of Millennium Development Goals for decreased infant and <5 mortality, and improved neonatal and maternal mortality, child nutritional status, and life expectancy. Tanzania also decreased HIV prevalence[iv],[29] and slightly increased married women's use of MCMs.[30] These initiated a shift in donor perceptions of Tanzania as transitioning towards middle-income status. This shift, however, is not one felt by the Adult Strategy's audiences due to Tanzania's high population growth rate (3.16%; 15th in the

[iv] Prevalence of HIV among adults ages 15 to 64 years in Tanzania is 5.0 percent (6.5 percent among females and 3.5 percent among males).

world),[v],[31] and disproportionate female disease burden,[vi] which speaks to issues of gender equity and the need for more effective SBCC. A brief situation analysis is provided by Life Stage Package below as of the time of drafting the original NAWEZA strategy. A more detailed review of the determinants of priority behaviors for each package is included in the Target Audiences, Communication Objectives, Illustrative Activities, and Media Mix Section of this document.

Pregnancy and Childbirth

The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health (RMNCAH) in Tanzania (2016-2020) ONE Plan II provides an overview of the critical RMNCAH issues to be addressed in Tanzania and translates all national policies and strategies into an enabling environment to enhance pregnancy outcomes via improved service provision from pre-pregnancy to the postpartum period. Key components included in the ONE Plan II include improvements to the number and timing of ANC visits, increased facility delivery rates, and promotion of EBF. The Tanzania Demographic and Health Survey (TDHS) 2015/16 report showed that attendance to ANC at least once is nearly universal (98%). However, it was found that women start ANC care late with only 25% of pregnant women attending their first ANC visit in the first four months of pregnancy.[32] The attendance at the previously-recommended four ANC visits has increased over time from 43% in 2010 to 51% in 2015/16 but is still far from achieving the national target of 90%.[33] Late attendance (after four months) to ANC, perception of the quality of antenatal services, and facility accessibility were all barriers to meeting the target of four visits throughout gestation.[34] For facility delivery, the TDHS indicates that the proportion of women giving birth in a health facility has slowly increased from 44% in 1999 to 63% in 2015/16.[35] However, postpartum care remains low with only 37% of mothers reporting attendance at a postpartum visit after their last live birth.[36]

The 2015/2016 TDHS reports that just 54% of pregnant women slept under an ITN the night before the survey was completed.[37] While sleeping under a ITN has increased between 2004 and 2016, there was a decline between 2011 and 2016 from 75% to the current 54%.[38] Net use remains consistent across urban and rural populations; however, use does increase with wealth quintile.[39] In 2015/2016, just over one third (35%) of women who had given birth in the last two years in Tanzania reported receiving more than two doses IPTp for malaria during pregnancy and only 8% reported receiving more than three doses.[40] This is an increase from the 2004 report in which only 21% women reported receiving two doses and only 3% reported receiving three or more.[41]

Caregiving for Children <5

Childhood mortality rates in Tanzania have been decreasing over the last 15 years, including neonatal mortality rate (40 deaths/1,000 live births in 1999 to 25 deaths/1,000 live births in 2015-16), infant mortality rate (99 deaths/1,000 live births to 43 deaths/1,000 live births), and under five mortality rates (147 deaths/1,000 live births to 67 deaths/1,000 live births).[42,43]

[v] High fertility (5.2 births/woman) reflects: 1) early marriage/motherhood, 2) low education, 3) gender-based violence, 4) multiple concurrent partnerships, 5) transactional sex, & 6) high unmet FP need, for higher risk & vulnerability to HIV & OIDs.

[vi] Adjusted maternal mortality ration/MMR: 460. UNICEF (2016). United Republic of Tanzania Statistics.

Although 98% of Tanzanian children are ever breastfed, the prevalence of EBF for under six months is 59% with only 27% of infants being EBF at 4-5 months.[44] More than half (51%) of the infants are breastfed within the first hour after birth, and 93% were breastfed within 24 hours after delivery.[45] Fourteen percent of infants are given pre-lacteal feeds before starting to breastfeed. By two months of age, 6% of infants are given semisolids or solids with an increase to 52% by 4-5 months.[46] Only 10% of children were fed a diet from the ages of 6-23 months that met Minimum Acceptable Diet requirements.[47]

Over the past decade household ownership and use of ITNs increased substantially, before decreasing in recent years. Household ownership of at least one ITN increased substantially from 23% in 2004-05 to 91% in 2011-12, before declining to 66% in 2015-16.[48,49,50] During this same time, use of ITNs among children under age 5 also increased from only 16% in 2004-05 to a high of 72% in 2011-12, before declining to 54% in 2015-16.[51,52,53]

Health care seeking for children with symptoms of malaria has improved, with advice or treatment being sought for 80% of children under five with a fever.[54] For 45% of these children, advice or treatment was sought immediately, either during the same or next day after the onset of fever.[55] Thirty-six percent of children under age five with a fever received a RDT for malaria.[56] Half of children under age five with a fever were given antimalarial medicines and, among these, 85% took an artemisinin-based combination therapy (ACT).[57] Malaria prevalence in Tanzania has increased from 9% in 2011-12 to 14% in 2015-16, according to RDT results. Malaria prevalence is highest among children from Geita, Kigoma, and Kagera regions and is more or less non-existent in Arusha, Njombe, Iringa, Dodoma, Kilimanjaro, and Manyara regions in mainland Tanzania and in all regions in Zanzibar.[58,59]

MCM use has increased over the last decade, with the modern contraceptive prevalence rate among married women in Tanzania increasing from 20% in 2004-05 to 32% in 2015-16.[60,61] Among sexually active unmarried women age 15-29, 54% are using contraception and 46% are using a modern method.[62] The most commonly used contraceptive method among currently married women is injectables (13%), followed by implants (7%), and pills (6%).[63] Among sexually active unmarried women, male condoms and injectables are the most commonly used methods (15% each), followed by implants (8%) and pills (6%).[64]

Total FP demand is high. Sixty-one percent of married women age 15-49 have a demand for FP; 39% want to space births, and 22% want to limit births.[65] About half (53%) of this existing demand for FP among currently married women is satisfied by the use of modern methods; however, 22% of currently married women have an unmet need for FP.[66] The unmet need for FP among currently married women has remained steady between 22% and 25% since 2004.[67,68,69]

Health Area Specific Campaigns: Test and Treat (*Furaha Yangu*)

The Tanzania HIV Impact Survey (THIS) 2016-2017 estimates HIV prevalence at 4.7% for adults age 15-49 years with significant variance between sex and age categories.[70] The survey shows the HIV epidemic in Tanzania continues to affect more women than men, with HIV prevalence more than double among women age 15-39 years than estimated among men from the same age category.[71] For women, HIV prevalence is highest among those age 45-49 years (12%) and for men, those age 40-44 years (8.4%).[72] While HIV prevalence among individuals age 15-

24 years remains below national HIV prevalence, young women in this age category are disproportionately more affected by HIV than their male counterparts (2.1% versus 0.6%, respectively). [73] The THIS highlights key weaknesses in the HIV treatment cascade in Tanzania, which impact the country's ability to reach its 90-90-90 goals by 2020. It is estimated that only 55.9% of female PLHIV and 45.3% of male PLHIV know their HIV status.[74] Among those who know their HIV status, 92.9% of female PLHIV and 86.1% of male PLHIV are engaged in treatment and 89.2% of female PLHIV engaged in treatment and 84% of male PLHIV engaged in treatment have achieved viral suppression.[75]

Over 80% of men ages 15-49 years are circumcised, with limited variance among age categories.[76] However, at least 14 regions have circumcision rates below the national average, from as low as 33.6% in Rukwa to 78.6% in Southern Highlands.[77] Service data from PEPFAR-supported voluntary medical male circumcision programs suggest that men age 25-29 years may be the most reticent to undergo the procedure.[78]

In 2017, there were 69,818 reported cases of TB, of which, 31% were among PLHIV.[79] While the number of TB cases has dropped among all populations since 2000, estimated TB incidence per 100,000 people remains higher among males than females (50 versus 104), and TB treatment coverage remains very low at 44%.[80] As a result, TB accounts for approximately 6% of all deaths among people over the age of 5 years.[81] Analysis conducted by the NTLP indicates that nearly a quarter of reported TB cases come from Dar-es-Salaam and together with five other regions (Mwanza, Shinyanga, Mbeya, Morogoro, and Mara) comprise the majority of reported TB cases.[82]

For individuals, families, and communities, there is a need for practical knowledge, changes in attitudes and norms, and improvements in skills to prevent HIV, malaria, and TB and initiate and adhere to treatment regimens; to increase MNCH and FP/RH behaviors; and to motivate and empower people to demand and seek appropriate services. For health care providers, there is a need for knowledge around changes in clinical guidelines as well as improved attitudes towards clients, skills to effectively communicate with and counsel clients free from stigma (and with kindness and empathy), and professional motivation. At the community, there is a need to challenge existing social and gender norms that negatively affect adoption of health practices.

This is the backdrop for the development of the Adult Platform.

Strategic Approach

The MOHCDGEC is being supported to develop and implement two complementary strategies that intersect at the community level. The Youth Strategy and Platform focuses on relationships, sexual and reproductive health, and HIV health issues with adolescents and youth under the age of 24; the Adult Strategy and Platform addresses the critical Life Stages of Pregnancy and Childbirth and Caregiving of an <5 child, and targets specific behaviors with clear messages and activities that reach into the emotions of audiences and address determinants and the context that drives behaviors. Determinants of critical Gateway, Accelerator, and other prioritized behaviors are being addressed via strategic use of mass media, interactive radio and community engagement, and interpersonal communication (IPC) to stimulate dialog among individuals, families, and communities. The two umbrella brands – for Adults and for Youth – reinforce and provide continuity and consistency to build trust as Platforms that facilitate accurate information and that actively engage individuals, families, and communities to address factors that inhibit SBC.

The MOHCDGEC is being supported to develop messages, activities, SBC tools, and media (as appropriate) for each Life Stage package and/or health area-specific campaign. Each includes a holistic set of activities with related materials/media designed to address key determinants of prioritized behaviors for segmented audiences. These include but are not limited to: mass media; community mobilization, community dialog, materials and tools to support IP's IPC activities; and guidance documents/trainings for partners supporting the implementation of this strategy.

Packages

Pregnancy and Childbirth Package: Addresses the needs of pregnant women and their partners (age 18-49). This package focuses on issues related to care seeking, prevention, and wellness for women during pregnancy and in the intra-partum period. Activities address norms, particularly male involvement and couples' decision-making and dialog, to create an enabling environment for the critical behaviors required for a healthy pregnancy and delivery – and to set the stage for a lifetime of positive interactions with the health system. This package advances the GOT's efforts to increase ANC 4 visits to 90% and contacts to 8, ANC before 12 weeks to 40%, IPT2 doses to 80%, ITN coverage to 80%, facility based deliveries to 90%, number of pregnant women tested for HIV to 100%, number of HIV positive individuals receiving ART to 90%, early initiation of breastfeeding (within 1 hour after birth) to 90%, and PNC attendance within 2 days to 60%.[83]

Parenting and Caregiving Package: Addresses the needs of caregivers of children under the age of 5, with a particular focus on the first 1,000 days. This package includes a focus on health care seeking behavior in addition to household-level preventative and wellness behaviors, including uptake and use of MCMs to ensure a well child and family. This package also contributes to specific National One Plan II Strategy (2016–2020) efforts to reduce neonatal mortality rates and increase ART prophylaxis for HIV exposed infants to 80%.[84]

Health Area-Specific Campaigns: There may be times where specific vertical, or health area-specific SBC campaigns are required (e.g. USAID Tulonge Afya supported the GOT to develop and implement the *Furaha Yangu* Test and Treat campaign). This strategy will be amended annually to incorporate these campaigns. ..

PBC: Addresses behaviors that facility- and community-based health providers can adopt to support the health and wellbeing needs of NAWEZA primary audiences. This increased emphasis, introduced in FY20, includes a focus on provision of non-biased, client-centered care, quality counselling, and adherence to clinical protocols. PBC activities will support NAWEZA's primary behavioral objectives through promotion of actions providers can take to facilitate adoption of priority behaviors by NAWEZA target audiences and mitigating provider-related barriers.

Emotional Drivers

To facilitate priority behaviors, the Adult Platform engages with individuals, families, and communities using emotion-based messaging that speaks to what audiences desire, or want, backed with practical actions they can take to have a successful pregnancy, a healthy child, or a well life. There are key established emotional drivers that influence behaviors. They range from status and love to wish fulfillment. Strategic formative audience consultations were conducted to ensure messaging under this Strategy pinpoints the critical issues that impact behaviors. Only by having this deep understanding can effective messaging and activities be developed. From the project's formative activities, the following were identified as key emotional drivers for its priority audiences:

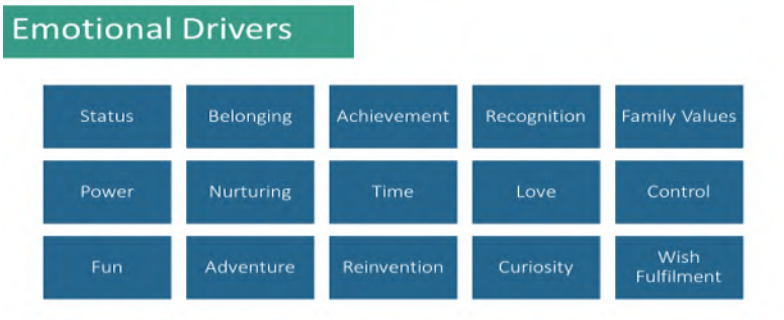


Figure 2. Emotional Drivers

Audience	Primary Drivers	Secondary Drivers
Pregnant women and mothers of young children	Nurturing Recognition Family values	Independence Control Status Security
Expectant fathers/fathers of young children	Status	Power Achievement Recognition Security
General population adult women and those being treated for TB	Independence Control	Achievement Recognition Belonging
General population adult men and those being treated for TB	Achievement	Recognition Status Belonging
PLHIV	Belonging	Control, Reinvention
Health care workers	Recognition	Status Nurturing

Branding and Positioning the Adult Platform

NAWEZA is a brand that is inspiring, connects, is authentic and is grounded in core desires and ambitions of Tanzanians. It is the brand that the Adult Platform will use. The Brand was developed after intensive research with key target audiences and geographies. All activities will stem from this brand or be linked to it to reinforce and confirm the key positive emotions that lead to positive decisions on the health and welfare of families and communities. Using HCD principles and based on the formative consultations, ideation workshops, and extensive pretesting, "NAWEZA" or 'I Can' promotes the vision that you can aspire to be the best version of yourself. Invoking your "Best Identity" - that could be as a father, a mother, a lover – the brand is also tied to "belonging" or togetherness, community, and a brighter future. A common element of the NAWEZA Brand is recognition of positive behaviors and the individuals and communities that are setting the stage for positive health behaviors.

NAWEZA Brand Manifesto

I can't always choose my circumstances. Or where I was born. But I CAN choose what I do to make my life better. And making my life better begins with recognizing that the most important choice I CAN make, is to keep myself and my family strong and healthy. Because when we are strong and healthy, we prosper more.

There are those who say "I CAN" and those who say "I HOPE". "I HOPE" is just a wish. But "I CAN" is a mindset. It says: I am the captain of my destiny. I am the master of my fate.

"I CAN" inspires me to be the best version of me, my best possible self.

I CAN be the best wife. I CAN be the best husband. I CAN be the best mama. I CAN be the best baba. I CAN do it!

I CAN be healthy. I CAN keep my family malaria free. I CAN have kids when I choose to. I CAN live a full life, even if I'm HIV

An initial teaser campaign established the brand, calling upon individuals and communities to join NAWEZA and adopt behaviors that can lead to healthier and happier families and communities. This initial campaign was co-designed with key stakeholders with representation of target populations.

NAWEZA Multimedia Channel Mix

A strategic media mix has been developed to ensure a seamless link between mass media, community activities, and IPC and that channels used under this Strategy are mutually reinforcing and stakeholders are working towards a common goal. The messages, channels, and media were developed to strategically engage target audiences by Life Stage, touching them emotionally to support action. Activities and channels were selected to reach individuals and create an enabling environment for positive behaviors.

At the national level, linking to specific Life Stages, SBC activities such mass media, have been implemented to establish the brand and set the stage for all subsequent messaging and activities at the regional, district, and community level. The brand has been used strategically to support overall umbrella messages for health care seeking behavior, treatment normalization, and high-

level prevention with greater focus on more targeted and supportive SBC activities at the community and facility level. A minimum package of activities and materials were developed to support each SBC package. Over the life of the project, additional materials and/or specific health issue campaigns will be added to enhance, and further target, or refresh the minimum package.

Underlying the development of all activities is the ADDED approach. Activities, media, and materials will be co-designed and where possible, co-delivered with and by the audiences. All activities will have feedback opportunities to adapt activities and messages to audiences' priorities, needs, and interests, and to address audience-identified behavioral barriers. This continual feedback loop will allow real time adjustment of activities for the greatest impact.

Target Audiences, Communication Objectives, Illustrative Messages, Activities, and Media Mix

Target Audiences

The following are the key target populations for the Adult Strategy. Detailed audience profiles, aligned to audience segment names presented below, can be found in **Annex A** of this strategy. The group that straddle both the adult strategy and the youth strategy are pregnant adolescents and young mothers under 18. This group will benefit from both strategies. The youth strategy will leverage the content from this strategy and package it within the youth for this age group. Those pregnant teenagers and young mothers may therefore be engaged by both NAWEZA and the Youth Brand.

Primary and Secondary	Pregnancy and Child Birth	Parenting and Care-Giving	Furaha Yangu (and some small broader TB SBCC under NAWEZA)

Primary	• Pregnant Women 18+*
	  ○ 1st pregnancy, single mom/ casual relationship (**Grace**)
	  ○ 1st pregnancy, cohabitating/ married (**Mwanaidi**)
	  ○ Experienced mom (2-3 kids) (**Aziza**)
	• Partners 18-49*
	  ○ 1st time father (**Songa**)
	  ○ Experienced father (**Bariki**)
	• Health Care Workers (HCW) (facility and community)**
	  ○ Facility-based worker (**Eliza**)
	  ○ Community-based worker (**Kabula**)
		• Parents and Care-Givers 18-49*
		  ○ New mother of baby <6 months (**Faraja**)
		  ○ Caregiver of 6 months to <2 (**Farida**)
		  ○ Caregiver of <5 (**Salha, Mariam**)
		• HCW (facility and community)**
		  ○ Facility-based worker (**Eliza**)
		  ○ Community-based worker (**Kabula**)
			• Those at greater risk for HIV or TB, including Men (18-24 – **Amani**, 25-45 – **Shukuru**) and those in higher risk occupations[vii], Pregnant and Lactating Women (**Assunta**), Key Populations (AGYW – **Nuru**), Caregivers of HIV Exposed Children (**Hulda, Romana**), people living with HIV [PLHIV] (**Shukuru, Assunta)**, People with TB (**Kilomo, Mwasiti**)
			• HCW**
			  ○ Facility-based worker (**Eliza**)
			  ○ Community-based worker (**Kabula**)

Secondary	• Influential family members • Traditional Leaders • Religious Leaders	• Influential family members • Traditional Leaders • Religious Leaders	• Influential family members • Traditional Leaders • Religious Leaders • General Population
***Note:** The Adult Platform will target audiences 18 years and older. This will allow some overlap with the Youth Platform targeted ages of 15-24 as there will be audience members who fall out of the youth strategy audience segments and whose needs are better addressed through the Adult Platform.			

[vii] Transportation, mining, construction, plantation, forestry, fishing, informal eateries on transport corridors, local brewers, and local bars

****Note:** While HCWs are reflected as primary audiences under each of the Life Stage packages and vertical health area-specific campaigns, objectives, activities, and materials addressing HCWs are expanded upon under a separate PBC sub-section below.

For each Package, barriers, facilitators, communication objectives, illustrative messages, activities, and a media mix are outlined. Communication objectives have been developed to address critical behavioral factors, as determined by use of baseline data, formative research, and/or secondary literature. They inform messaging and activities developed.

Activities have been, and will continue to be, developed to specifically address the prioritized behaviors outlined. The SBC Packages per Life Stage allow for cross messaging and development of tools for all levels of engagement – from national to community and at family levels.

From radio talk shows, community dialogs, home visits, and community events (supported by USAID Tulonge Afya), to household and facility IPC (supported by other USG implementing partners) the Platform capitalizes on existing systems and community channels to engage with a wide range of audiences including community opinion leaders and enlist them as partners in the project. Health workers play a key role across all Life Stages and campaigns and have similar behaviors that can inhibit health care seeking behavior and adherence to treatments. They are included as audiences for each of the SBC Packages but are also addressed separately under the PBC section, which was added to the Adult Strategy in FY20.

Life Stage Package #1: Pregnancy and Childbirth

Audience consultation research, literature reviews, a Gender and Youth Assessment, social norms exploration, LTFU study, and household baseline identified barriers and facilitators towards adoption of promoted behaviors. Other resources and lessons from previous projects were used to further review barriers to determine their importance and changeability in the Tanzanian context, which informed the selection of communication objectives.

Key Primary and Secondary Audiences: Pregnant Women (Grace, Mwanaidi, & Aziza) their Partners (Songa & Bariki), Health Care Providers (Eliza & Kabula) and Other Influential Family and Community Members

Desired Behaviors	Barriers and Facilitators	Communication Objectives
Go early, attend, and complete more than 4 ANC visits (8 contacts are desired) Focus: Increased demand and action	***Knowledge:*** • Confusion (where to get services, visit frequency)[85]; Current policy shift from 4 ANC visits to 8 contacts • Lack of awareness of ANC benefits[86] ***Motivation:*** • *Beliefs:* ANC is for the sick[87] or new or 'soft' moms[88]; Fear that a pregnancy might be doomed if you go to ANC too early (local insight) • *Attitudes:* Desire to avoid several clinic visits[89] ***Ability to Act:***	***Pregnant women*** • Increase in the percentage of pregnant women who know where and when to obtain ANC services • Increase in the percentage of pregnant women who feel confident to attend ANC early and more than four times *(ideal behavior is 8 ANC*

Key Primary and Secondary Audiences: Pregnant Women (Grace, Mwanaidi, & Aziza) their Partners (Songa & Bariki), Health Care Providers (Eliza & Kabula) and Other Influential Family and Community Members		
Desired Behaviors	**Barriers and Facilitators**	**Communication Objectives**
	• *Self-Efficacy:* As confidence and ease in attending ANC improves, respondents were more likely to attend ANC 4 times (p<.07)[90] • *Access:* Mistreatment of pregnant patients by providers (neglect, extortion, verbal abuse)[91]; Some women are not given an ANC card[viii]; Health care workers may turn away women for ANC if not accompanied by a male partner or who are early in their pregnancy[92] • *Access:* For Men, cost and time are barriers[93]; Long distances to facility[94] ***Norms:*** • *Gender norms:* Women are often unable to participate in HH decision-making[95],[96]:[97]; men's permission and monetary support to access services is needed[98]; Norms around masculinity discourage male engagement in MNCH care, such as attending ANC visits with partners[99] • *Socio-cultural norms:* Polygamy may impact level of engagement of fathers in their child and wives' care[100] **Facilitators:** • Those who recall messages on the importance of ANC were more likely to complete 4 visits (p<.05)[101] • Men may see ANC as prevention for future costly emergencies[102]	*contacts; doable behavior may be more than 4)* • Increase in the percentage of pregnant women who believe going to ANC early and more than 4 times, regardless of parity, benefits them and their baby ***Partners*** • Increase in the percentage of partners of pregnant women who believe they should support (accompaniment and provision of resources) their pregnant partners to attend ANC • Increase in the percentage of partners of pregnant women who believe men like them support their partners to attend ANC •
Take IPTp-3 during ANC visits Focus: Increased demand and action	*See ANC above for additional factors* ***Ability to Act:*** • *Self-efficacy:* Those who took IPTp[ix] were more likely (p<.0001) to report confidence taking medicine during pregnancy[103]; As confidence improves, respondents were more likely to report taking IPTp (p<.0001)[104]; Those who took IPTp were more likely (p<.05) to report ease in accepting IRS sprayers in their homes[105] • *Dialog:* Pregnant women who took IPTp were more likely (p<.05) to have discussed preventing malaria in pregnancy (past 6 months) than those who did not[106] **Facilitators** • Respondents who recalled IPTp messages were more likely to have taken IPTp (p<.01) [107]	*See ANC above for related communication objectives* ***Pregnant women*** • Increase in the percentage of pregnant women who feel confident in their ability to prevent malaria during their pregnancy, including taking IPTp ***Pregnant women and their partners*** • Increase in the percentage of pregnant women and their partners who believe it is important to discuss

[viii] ANC cards are given to mothers when they visit ANC for the first time. Women may be denied services if they don't have the card (because they came late or unaccompanied by a male partner). This can be problematic for ANC completion, facility birth, and for accessing post-partum and child health services.

[ix] Pregnant women or mother of a child under 10 months

Key Primary and Secondary Audiences: Pregnant Women (Grace, Mwanaidi, & Aziza) their Partners (Songa & Bariki), Health Care Providers (Eliza & Kabula) and Other Influential Family and Community Members		
Desired Behaviors	**Barriers and Facilitators**	**Communication Objectives**
	• Most pregnant women believed taking IPTp was easy (40.1%) or very easy (55.7%) to do[108]	preventing malaria during pregnancy with each other
Sleep under an ITN every night, including pregnant women Focus: Increased demand, action, and maintenance	***Knowledge:*** • Belief bed nets cause bed bugs[109] • Effectiveness of ITNs sometimes questioned (people who use them still get malaria)[110] ***Motivation:*** • *Beliefs:* Malaria is caused by witchcraft; healed only by traditional healers[111]; ITNs/chemicals harm virility[112],[113]; Safety concerns of treated nets[x114]; suspicion of organizations giving nets[115]; Belief there are no mosquitos[116] • *Attitudes:* That Malaria is only an inconvenience[117]; Nets viewed as a priority for some seasons, populations, or conditions but not everyone[118] ***Ability to Act:*** • *Product:* Nets considered uncomfortable[119]; Non-use when it is too hot, or the net is old or dirty[120] • *Skills:* Suboptimal or incorrect usage[121] • *Access:* One study found non-affordability was a deterrent to use[122]; another study found socioeconomic status was not a significant determinant ITN use[123] **Facilitators:** • High ITN knowledge as a method to prevent malaria[124] • Strong overall demand for nets[125] • Some have used bed nets a long time and now the practice is routine[126] • ITNs are convenient and available in many contexts[127] • A qualitative study found that bed nets were frequently mentioned and described as 'part of the culture' in the least wealthy locations[128] • Child ITN use generally increases with wealth[129]	***Pregnant women and their partners*** • Increase in the percentage of pregnant women and their partners who believe there is a heightened risk of malaria in pregnancy • Increase in the percentage of pregnant women and their partners who believe an ITN is safe and effective to use • Increase in the percentage of pregnant women and their partners who believe that ITNs prevent nuisance bugs that can disturb sleep
Attend PMTCT services and take ART as prescribed if HIV+ Focus: Increased demand, action, and maintenance	***Motivation:*** • *Beliefs:* Overarching fear of HIV+ diagnosis (loss of control, not achieving dreams)[130]; Fear of physical violence and being assumed unfaithful[131]; Fear of losing support of loved ones/ not belonging[132]; Caregivers of an HIV exposed child: Fear of result for child or that HIV+ test will give away their status[133]; Concerned about side effects/safety of ART on infants and themselves[134] • *Attitudes:* Asymptomatic HIV+ pregnant women may feel ART during pre-natal care is unnecessary[135]	***Pregnant women*** • Increase in the percentage of pregnant women who feel confident in their ability to attend PTMCT services ***Pregnant women and their partners*** • Increase in the percentage of pregnant women and their partners who believe that HIV

[x] Mind control, fertility control

Key Primary and Secondary Audiences: Pregnant Women (Grace, Mwanaidi, & Aziza) their Partners (Songa & Bariki), Health Care Providers (Eliza & Kabula) and Other Influential Family and Community Members		
Desired Behaviors	**Barriers and Facilitators**	**Communication Objectives**
Linkage with Furaha Yangu	***Ability to Act:*** • *Access:* Logistical concerns of post-natal infant ART adherence[136]; Economic concerns[137]; Rural women are less able to access care[138] • *Dialog:* Most participants indicated they were comfortable talking with their partner about PMTCT services (yet only 36.5% of pregnant women have discussed PMTCT in the last 6 months). Younger pregnant women were less likely to have discussed PMTCT[139] • *Support:* Partner support may increase adherence to ART[140]; Lack of support for young mothers and those without partners[141] ***Norms:*** *Gender/socio-cultural norms:* Young HIV+ pregnant women commonly face discrimination in health facilities[142]	is a manageable chronic condition for them and their child(ren) ***Partners of pregnant women and*** • Increase in the percentage of <u>partners of pregnant women</u> who desire a supportive role (including accompaniment and provision of resources) in their partners' ANC and PMTCT care •
Attend a health facility for delivery Focus: Increased demand and action	***Ability to Act:*** • *Access:* HCW advice is given harshly[143] ; Poor treatment by medical providers during ANC influences delivery choice[144]. For Men: Mistreatment or abuse by HCW were also reported[145]; In rural areas, distance to the facility and poor road infrastructure are barriers[146] ***Norms:*** • *Gender norms:* Men's permission and monetary support are necessary[147] **Facilitators:** • Repeated exposure to ANC services and HIV counseling/testing were positively associated with health facility childbirth[148] This was corroborated by the Baseline, which found that those who attended ANC were more likely (p<.0001) to report delivering their last baby at the facility or intending to[149]. • Perceived quality of facility and trust in services is positively associated with a facility birth[150]; perceived cost is positively associated with facility use in urban areas (i.e. cost is presumed to be an indication of quality of services)[151] • One study found that nurses and mid-wives who felt empowered through better management of the hospital (even in a resource-poor environment) provided improved maternal care to patients.[152]	***Pregnant women*** • Increase in the percentage of <u>pregnant women</u> who believe they will receive quality services at the health facility ***Pregnant women and their Partners*** • Increase in the percentage of <u>pregnant women and their partners</u> who feel confident in their ability to plan for a facility delivery ***Partners of pregnant women*** • Increase in the percentage of <u>partners of pregnant women</u> who believe other men like them support their partners to have a health facility delivery •
Initiate breastfeeding (BF) within the	***Knowledge:*** • The less a mother knows about newborn danger signs the less likely she will initiate early BF[153]	***Pregnant women*** • Increase in the percentage of <u>pregnant women</u> with

Key Primary and Secondary Audiences: Pregnant Women (Grace, Mwanaidi, & Aziza) their Partners (Songa & Bariki), Health Care Providers (Eliza & Kabula) and Other Influential Family and Community Members

Desired Behaviors	Barriers and Facilitators	Communication Objectives
first hour of birth Focus: Increased action and maintenance	• Lack of knowledge of benefits of early BF[154] • Only 51% of women in a study reported that they had received counselling on BF[155] ***Ability to Act:*** • *Access:* Early initiation of BF is impacted by the HIV status of the mother and access to PMTCT [156]; Facility practices leading to separation of mother and infant in the early hours after birth, tiredness after a lengthy labor, and caesarean sections[157]; Poor mothers and those with limited access to services were less likely to BF early and have intentions of early BF[158] ***Norms:*** • *Socio-cultural norms:* Some cultural norms lead mothers to discard colostrum and give other traditional foods and fluids[159] • *Place of deliver:* 60% of children born in facilities were breastfed within 1 hour of birth vs. only 40% of children delivered elsewhere[160]; most mothers in one study breastfed within an hour[161]; Women who deliver in a facility are twice as likely to initiate early BF than those who deliver at home[162]; Odds of early initiation of BF is lower among women who delivered via cesarean[163]; 10% of children born in a facility were given a pre-lacteal feed vs. slightly more than two in ten children born outside a facility[164] **Facilitators:** • Most women understand colostrum's importance[165] Most (70%) women knew that it was important to initiate BF within one hour of birth[166]	knowledge of the benefits of early BF • Increase in the percentage of <u>pregnant and newly-delivered women</u> who feel confident in their ability to initiate early BF and to say no to pre-lacteal feeds ***Partners of pregnant women and other influential family members*** Increase in the percentage of <u>partners of pregnant women and other influential family members</u> who believe that supporting mothers for early initiation and EBF (including no pre-lacteal feeds) is respected by their community
Talk with your health care provider about post-partum FP options Focus: Increased demand and action	***Knowledge:*** • Lack of comprehensive MCM information from providers may cause distrust[167] • Men: primarily concerned about wives' experiencing side effects (excessive bleeding, illness, infertility) or passing illness to BF children[168] ***Motivation:*** • *Beliefs*: FP causes infertility, prolonged/irregular bleeding, cervical cancer, fibroids, birth defects, and prolonged labor[169] as well as sterility (hormonal methods)[170]; MCM side effects foster laziness and may induce infertility[171] ***Ability to Act:***	***Pregnant women*** • Increase in the <u>percentage of women</u> who demonstrate correct knowledge about MCMs • Increase in the <u>percentage of women</u> who believe their partner supports the use of an MCM ***Pregnant women and their partners***

Key Primary and Secondary Audiences: Pregnant Women (Grace, Mwanaidi, & Aziza) their Partners (Songa & Bariki), Health Care Providers (Eliza & Kabula) and Other Influential Family and Community Members

Desired Behaviors	Barriers and Facilitators	Communication Objectives
	• *Dialog:* Those who use MCMs were more likely (p<.001) to have reported discussing MCMs with someone (last 6 months). Most respondents (users and non-users, alike) discussed MCMs to space births, followed by delaying pregnancy, and limiting births[172]; Un-comfortability discussing topic with a doctor of the opposite sex (e.g. males view asking questions about sexual health as emasculating with female providers[173]). This is also an issue in terms of provider age (e.g. when a female provider is younger than a female patient)[174] • *Product:* Side effects of hormonal MCMs may prevent sustained use for some, particularly in the postpartum period[175] • *Access:* Shortage of health workers, HCW limited time[176], supply shortages[177], long distances to facilities[178]; Religion does not condone their use[179]; Fear of domestic violence[180] • *Support:* Partner disapproval was the second leading cause of MCM nonuse in one study (after amenorrhea)[181]; Difficulty advocating for FP, especially condoms[182] • *Stigma & discrimination:* Stigma against MCM use in some contexts[183] ***Norms:*** • *Socio-cultural:* Religious opposition to MCM may deter use[184]; Cultural norms stipulate a large family is a good[185]; Social norms dictate that the primary expectation of married women is to bear many children[186] **Facilitators:** • Those who use an MCM are significantly (**p<.0001, OR 59**) more likely than those who do not to report confidence in obtaining information about, discussing, and using (if desired) contraception[187]. • Those with general contraception knowledge are significantly **(p<.0001, OR 10.628)**) more likely than those without to report use of an MCM[188] • Those who perceive that their partner supports use of contraception are significantly (**p<.0001, OR 7.588**) more likely to use an MCM than those who don't[189] • MCM 'doers' are significantly more likely to believe their closest friends use an MCM (p<.0001, OR 4.778), have discussed contraception in the last six months (p<.0001, OR 3.450), have positive attitudes towards family planning (p<.0001, OR 2.843), and to know more	• Increase in the <u>percentage of women and their partners</u> who feel confident discussing use of MCMs ***Partners of pregnant women*** • Increase in the <u>percentage of partners</u> who have supportive attitudes towards their partner's use of MCMs

Key Primary and Secondary Audiences: Pregnant Women (Grace, Mwanaidi, & Aziza) their Partners (Songa & Bariki), Health Care Providers (Eliza & Kabula) and Other Influential Family and Community Members		
Desired Behaviors	**Barriers and Facilitators**	**Communication Objectives**
	than one source of information about contraception (p<.0001, OR 1.600) [190] • Higher levels of maternal education were associated with postpartum MCM use in one study[191] • Positive views of MCM due to health and economic benefits of limiting and spacing children[192] High levels of postpartum FP use in the community is associated with maternal postnatal care seeking	
Attend PNC visits and seek and receive prompt and appropriate care at the health facility upon first sight of postpartum danger signs Focus: Increased demand and action	***Knowledge:*** • Low awareness of post-partum care benefits for infants and mothers[193] • Lack of knowledge of signs and symptoms of serious illness (both the infant and mother)[194] • Lack of prior counselling on danger signs contributes to poor post-natal care access[195] ***Motivation:*** • *Attitudes:* Mothers with more than one child and women who delivered in health clinics do not believe postpartum care is necessary (they consider their delivery as a postpartum assessment) [196]; Mothers with unwanted pregnancies were less likely to attend post-natal care services[197] • *Beliefs:* Postpartum services perceived as being of poor quality (due to lack of resources, disrespectful providers)[198] ***Ability to Act:*** • *Access:* Lack of transport money; time to mobilize cash[199]; Fear of encountering wild animals enroute, shortages of staff, equipment, and supplies[200]; Long wait times[201]; Provider harassment and insistence of informal payments or bribes for postpartum services[202] **Facilitators:** • Being counseled by a community health worker (CHW) to attend PNC[203] • Mothers who attended ANC services more frequently were more likely to receive PNC services than those who attended fewer than 2 ANC services[204] • Women delivering at home were more likely to attend PNC than those who delivered at a facility[205] • Those with a complicated mode of delivery were more likely to come as part of follow up care[206]	***Pregnant women*** • Increase in the percentage of pregnant women who know pregnancy and post-partum danger signs • Increase in the percentage of pregnant women who believe that getting a postnatal check-up benefits them, regardless of parity or place of delivery •
Bring your infant to the health facility for an early visit	***Knowledge:*** • Inadequate knowledge/awareness of EID services[207] • Lower odds of EID for children born to mothers with unplanned pregnancies or unknown HIV status at	*Additional research is needed on this behavior* ***Caregivers of <5***

Key Primary and Secondary Audiences: Pregnant Women (Grace, Mwanaidi, & Aziza) their Partners (Songa & Bariki), Health Care Providers (Eliza & Kabula) and Other Influential Family and Community Members		
Desired Behaviors	**Barriers and Facilitators**	**Communication Objectives**
at 4-6 weeks, and for HIV testing if mother is positive or status unknown Focus: Increased demand and action	conception. Likewise, lower odds to access EID were observed among children with mothers/guardians who did not know the age when the first HIV test of the child ought to be performed[208] ***Motivation:*** • *Beliefs:* Children appeared to be in good health and so the guardians felt there was no need to access the services[209], and lack of paternal permission or support[210] ***Ability to Act:*** • *Stigma & discrimination:* Fear of stigma results in low uptake of integrated services (childhood immunization and HIV services)[211]; HIV testing at immunization appointments[212]; Mothers' HIV status is often indicated on an antenatal card that is presented at the clinic[213] **Facilitators:** • Children with mothers/guardians who were married/living with their spouses and with good knowledge of HIV prevention and transmission from mother-to-child were statistically significant predictors of accessing EID at the age of 4–6 weeks[214] • Mothers are in favor of integrated health service provision that includes HIV testing for both her and her child at wellness and immunization visits[215]	• Increase in the percentage of caregivers who know when and where to access EID/ integrated services • Increase in the percentage of caregivers who feel confident in their ability to obtain EID/integrated services •

Pregnancy and Childbirth

Promoted Behavior	Key Promise	Illustrative Messages[xi]
• Go early, attend, and complete **more than** four ANC visits (8 contacts desired) • Take IPTp-3 during ANC visits • Sleep under an ITN every night, including pregnant women • Attend PMTCT services and take ART as prescribed if HIV+	My future is secure when I invest in my baby now By providing a healthy start in life, my baby will be more successful in school, get a good job, and will be able to provide for me when I am old I am a great mother who knows how to show love to my baby by protecting her and ensuring her future I can secure a better future by planning my family	Your health worker can provide you with the best care and information for you and your child – learn how to get the most from your health care system Going to the health facility for delivery improves your chances of having a safe delivery and a healthy baby If you take steps to prevent and treat malaria, you will be seen as a great mom/dad who loves and protects their child

[xi] Messages are developed and tested with audience members and contextualized as part of the creative development process

• Attend a health facility for delivery • Initiate breastfeeding within the first hour of birth • Talk with your health care provider about post-partum FP options • Attend postnatal visits and seek and seek and receive prompt and appropriate care the health facility upon the first sight of post-partum danger signs • Bring your infant to the health facility for an early visit at 4-6 weeks and for HIV testing if mother is positive or status unknown	I will be recognized by my community for playing a supportive role in my wife and child's care	Support your pregnant wives/partners to get the best possible care for your unborn child MCMs give you the freedom to take care of your newborn – they allow you ample time to raise your new child and participate in social and economic activities, so you can ensure the best for your family. Talk to your doctor about MCM use after your baby is born. You can be proud of protecting your baby by completing each essential pregnancy action You will be a strong and caring mother by going to ANC early and at least 4 times (ideally 8 contacts) to ensure the health of your baby

Activity and Materials Package for the Pregnancy and Childbirth Package

Under the umbrella of NAWEZA, the focus is on getting women into ANC early and often and to deliver in a facility; male partner support; and instilling trust in the health care workers and the health care system – as well as on preventative behaviors to be taken at home (e.g., ITN use) and appropriate care seeking. Activities focus on stimulating community dialog on how to support pregnant women. A variety of channels are being used, from mass media, to set normative behaviors and model early adopters, to community and interpersonal channels to facilitate dialog, address barriers, and build skills and confidence in carrying out promoted behaviors. During rainy season targeted malaria activities are also implemented.

	ANC	IPTp	ITN	PMTCT	Facility Delivery	Early BF	Talk MCM	PNC	Child visit/ EID
Mass Media									
Radio show	X	X	X	X	X	X	X	X	X
Radio spots	X		X		X			X	
Community radio	X	X	X	X	X	X	X	X	X
Health expert interview	X		X		X				
DJ presenter mentions	X		X		X			X	
Social media	X	X	X			X	X		
SMS	X	X	X		X	X	X	X	
Elimu ya Afya[xii]	X	X	X	X	X	X	X	X	X
Billboards	X		X		X				
Mid-media									
Community theater	X	X	X	X	X	X	X	X	X

[xii] This is the former m4RH program that has not been adapted by the GOT and will include all health areas

IPC									
Household & facility counseling*	X	X	X	X	X	X	X	X	X
Small group dialog	X	X	X		X	X	X		
Community /religious leader mobilization	X		X	X	X				X
Orientations									
Providers	X	X	X	X	X	X	X	X	X
IPs	X	X	X	X	X	X	X	X	X

***Including timed household visits implemented by USAID Tulonge Afya as well as counseling** implemented by other USG implementing partners with USAID Tulonge Afya support tools.

Activities and Supporting Media/Materials

- Radio show: A long-running radio show, NAWEZA, showcases real life stories related to the behavior and norm change priorities supported through the Life Stage packages. Stories showcase how audiences have addressed and overcome key barriers of these behaviors.
- Radio spots are aired nationally and regionally for select behaviors with priority emphasis on those likely to affect multiple health outcomes. In addition to spots on health topics, radio spots are developed to promote male engagement.
- Community radio localizes content, engages communities in dialog, and recognizes community members' success in achieving healthy behaviors. Stations are supported through the following products:
    - Community Radio Guide
    - Community Radio Training
    - Supplementary Topic Guides
- Social media targets first time mothers in urban and peri urban areas using Facebook, Instagram, and WhatsApp
- SMS is used to send supportive messages; Elimu ya Afya (formerly M4RH) is a GOT pull SMS service where messages are incorporated from across the health areas
- Billboards are used in strategic locations to emphasize key calls to action
- Community theater engages audiences in reflection and dialog around the key behavior and norm change priorities, barriers and facilitators, and generates community-driven solutions to their uptake. Community theater is supported by development of a Community Theater Guide and Community Theater Scripts.
- Timed household counseling visits are implemented by USAID Tulonge Afya-supported CHWs to reach pregnant women and new mothers at key time points in their pregnancy and postpartum journey. Visits incorporate discussion and counseling related to all health areas, as well as linkage and referral to care.
- Household and facility level counseling is conducted by CHWs and community volunteers using job aids that incorporate all health areas and on targeted behaviors as appropriate. Support is provided to USG implementing partners, such as the USAID Boresha Afya projects through the provision of 1:1 IPC tools.
- Community dialog aims to build skills and confidence, identify solutions to barriers, and create a sense of support among peers. For each package an interactive community dialog toolkit has been developed (with expansion and additional targeting over the life of the strategy).
- Community/religious leader mobilization to support uptake and attention for priority behaviors and/or address barriers to care will be advanced through development of a Community and Religious Leader Mobilization Guide
- Orientations for providers and IPs on use of the Life Stage packages include development of a Service Provider Orientation, Provider Do/Don't Do Counseling Videos , and a Life Stage Package Implementation Guide. An expanded set of provider-focused tools and activities are described under the PBC section
- Other print materials:
    - NAWEZA Actions for a Healthy Pregnancy Card
    - Service invitation coupons
    - Safe pregnancy commitment boards/pledges
    - Early ANC postcard (young newly pregnant, experienced mothers, and those not yet expecting)
    - Appointment/key milestones reminder tool
    - Key milestones facility poster

- Posters (e.g. male engagement), brochures (e.g. helping families plan and choose a facility delivery, navigating the health system), billboards, etc.

Life Stage Package #2: Caregiving for Children Under Five

Key Primary and Secondary Audiences: Caregivers of Children <5 (Faraja, Farida, Salha, Mariam), Health Care Providers (Eliza & Kabula), Influential Family and Community Members.

Desired Behaviors	Barriers and Facilitators	Communication Objectives
Sleep under an ITN every night, including children under five Focus: Increased demand, action, and maintenance	***Knowledge:*** • Belief bed nets cause bed bugs[216] • ITN effectiveness for malaria prevention may be questioned as people who use them still get malaria[217] ***Motivation:*** • *Beliefs:* Malaria is caused by witchcraft and healed only by traditional healers[218]; ITNs/chemicals may harm virility[219]; Safety concerns of treated nets[xiii][220]; suspicion of organizations giving nets[221]; Belief there are no mosquitos[222] • *Attitudes:* Malaria is perceived as only an inconvenience[223]; Nets viewed as a priority for some seasons, populations, or conditions but not everyone[224] ***Ability to Act:*** • *Product:* Nets considered uncomfortable[225]; Non-use when it is too hot, the net is old or dirty[226] • *Skills:* Suboptimal or incorrect usage[227] • *Access:* One study found non-affordability was a deterrent to use[228]; another study found socioeconomic status was not a significant determinant ITN use[229] **Facilitators:** • High ITN knowledge; ITNs were the most commonly mentioned method of protection[230] • Strong overall demand for nets[231] • Some have used bed nets a long time and now the practice is routine[232] • ITNs are convenient and available in many contexts[233] • A qualitative study found that bed nets were frequently mentioned and described as 'part of the culture' in the least wealthy locations[234] • Child ITN use generally increases with wealth[235]	***Caregivers of <5*** • Increase in the percentage of caregivers who believe malaria is a serious threat for under-five children • Increase in the percentage of caregivers who believe an ITN is safe and effective to use • Increase in the percentage of caregivers who believe that ITNs prevent nuisance bugs that can disturb sleep
After a live birth, use an MCM to avoid pregnancy for	***Knowledge:*** • Lack of information on MCM from providers may cause distrust[236]; lack of information on how to manage side effects may lead to discontinuation[237]	***New mothers*** • Increase in the percentage of women who demonstrate correct knowledge about MCMs

[xiii] Mind control, fertility control

at least 24 months Focus: Increased demand, action, and maintenance	• Men: concerned about wife's side effects (excessive bleeding, illness and/or becoming infertile) or passing illness to breastfeeding children[238] ***Motivation:*** • *Beliefs*: Condoms can make a penis swell, cause allergic reactions for women, are contaminated with a virus to kill users, and may reduce the bond between sexual partners[239]; FP causes infertility, prolonged and irregular bleeding, cervical cancer, fibroids, birth defects in future children, and prolonged labor due to previous use[240]; Misperception that hormonal methods are associated with sterility[241]; That MCM side effects foster laziness[242] ***Ability to Act:*** • *Dialog:* Discomfort discussing FP with a doctor of the opposite sex (e.g. male patients who view asking questions about sexual health as emasculating if their provider is female)[243]; this is also an issue in terms of provider age (e.g., when a female provider is younger than a female patient)[244] • *Product:* Side effects of hormonal MCM[245] • *Access:* Long distances[246]; Shortage of HCWs and time[247]; shortage of MCM supply[248]; Religion does not condone their use[249] • *Stigma & discrimination:* Stigma against MCM[250] • *Support:* Partner disapproval[xiv],[251]; Fear of domestic violence[252]; Women have difficulty advocating for FP, especially condoms[253]; some men discourage/oppose FP use[254]; Mothers-in-law influence their son's views on FP and family size[255] ***Norms:*** • *Socio-cultural:* Religious opposition[256]; Cultural norms stipulate that a large family is a good[257]; Social norms dictate that the primary expectation of married women is to bear many children[258]; Household decision-making, including deciding when and how many children to have, is the man's role;[259] Family size is closely tied to perceptions of masculinity[260] **Facilitators:** • Those who use an MCM are significantly (**p<.0001, OR 59**) more likely than those who do not to report confidence in obtaining information about, discussing, and using (if desired) contraception[261]. • Those with general contraception knowledge are significantly **(p<.0001, OR 10.628)**) more likely than those without to report use of an MCM[262] • Those who perceive that their partner supports use of contraception are significantly (**p<.0001, OR 7.588**) more likely to use an MCM than those who don't[263]	• Increase in the <u>percentage of women</u> who believe their partner supports the use of an MCM ***New mothers and their partners*** • Increase in the <u>percentage of women and their partners</u> who feel confident discussing use of MCMs ***Partners of new mothers*** • Increase in the <u>percentage of men</u> who have supportive attitudes towards their partner's use of MCMs • Increase in the <u>percentage of men</u> who do not believe their value as a man is tied to the size of their family ***Older, influential woman (e.g. mothers, mothers-in-law, aunties)*** • Increase in the <u>percentage of older, influential women</u> who have supportive attitudes towards use of MCMs

[xiv] 2nd leading cause of MCM nonuse in one study after amenorrhea

	• MCM 'doers' are significantly more likely to believe their closest friends use an MCM (p<.0001, OR 4.778), have discussed contraception in the last six months (p<.0001, OR 3.450), have positive attitudes towards family planning (p<.0001, OR 2.843), and to know more than one source of information about contraception (p<.0001, OR 1.600) [264] • Higher levels of maternal education were associated with postpartum MCM use in one study[265] • Positive views of MCM due to health and economic benefits of limiting and spacing children[266] • High levels of postpartum FP use in the community is associated with maternal postnatal care seeking • High levels of PPFP use in the community was associated with maternal postnatal care seeking[267]	
Exclusively breastfeed your infant for six months after birth Focus: Increased demand, action, maintenance, and advocating	***Knowledge:*** • Only 51% of women in a study reported they had received counselling on BF[268] ***Motivation:*** • *Beliefs:* Breastmilk is insufficient to meet the nutritional needs of an infant; the child is thirsty, and the need to introduce herbal medicine remedies[269] ***Ability to Act:*** • *Intention:* As intention to EBF improves, respondents were more likely to have reported EBF (p<.01)[270] • *Access:* Insufficient milk.[271] • *Support:* Intimate partner violence adversely affects optimal BF practices in certain conditions.[272] ***Norms:*** • Even if infants 0-6 months are primarily breastfed, complementary foods tend to be introduced too early[273] **Facilitators:** • Young mothers who delivered at a health facility, who weren't away from their infants for long periods of time, and who received strong support from their community or madrassa reported higher rates of EBF their infants 0-6 months, regardless of knowledge about EBF benefits.[274] • Respondents were more likely to report EBF as exposure to messages around EBF increased (p<.05)[275]	***New mothers*** • Increase in the percentage of new mothers who believe that breast milk alone until 6 months is sufficient to meet her infant's nutritional needs • Increase in the percentage of new mothers who believe it is important to wait until 6 months of age to begin complementary feeding • Increase in the percentage of new mothers who intend to exclusively breast feed their baby for the full 6 months ***Partners of new mothers and other influential family and community members*** • Increase in the percentage of partners of new mothers and other influential family and community members who believe that supporting mothers to EBF is respected in their communities
Seek and receive prompt and appropriate care at first sign of newborn and childhood illness	***Motivation:*** • *Beliefs:* Mothers, in one study, based ARI care decisions on symptom severity, preferring modern medicine for persistent symptoms[276]; Were aware of antibiotics but they were not often used at home as they were perceived to be for hospital care[277] ***Ability to Act:*** • *Skills:* Few facilities have providers who have received recent in-service training related to child health[278]	***Caregivers of <5*** Increase in the percentage of mothers and fathers who believe that the health facility is the first place they should take a sick child • Increase in the percentage of caregivers who intend to take

Focus: Increased demand and action	• *Access:* Medication and transport costs[279]; children in poor homes less likely to receive care or home care for illness[280]; Distance to health facility[281, 282;] Security: lack of transport when a child is ill at night[283]; Households with more than one child<5 are more likely to delay care-seeking[284], not seek care, only provide home care[285],[xv]. Presence at home of both parents was associated with prompt care-seeking vs. when one or both parents are not home[286]; A few caregivers (2%) cited poor provider behavior/ attitudes as a major problem in seeking services for child illness[287]; Lab diagnostic capacity is limited at facilities[288]; 18% of caregivers cited non-availability of medicines for dissatisfaction with child services received[289]; 3 essential medicines/commodities (oral rehydration solution [ORS], mebendazole/ albendazole and ACT) were in stock in about 9% of facilities. Availability of other essential medicines ranged from 44 percent to 73 percent[290]; 16% of caregivers cited long wait times as a reason for dissatisfaction with child health services received[291] ***Norms:*** • *Gender norms:* Many women report they make care seeking decisions but often consult the father or a neighbor first[292]; it's considered a woman's responsibility to communicate a child's health issue to the father and it's their decision whether the child should be taken to the hospital for treatment. If the father grants permission, it is not common for him to attend the visit with her[293]. • *Socio-cultural norms:* Some first try home remedies for ARI or use drugs from previous prescriptions[294] ; home remedies such as honey, lemon, eggs, milk, garlic, ginger, and bicarbonate soda are common[295]; Caregivers are more likely to delay seeking[296], or not seek care[297] for older children under five; Traditional healers were sometimes consulted but generally considered to belong to the "old days" and not a frequent source of care for childhood illness in one study[298] **Facilitators:** • Awareness of common childhood illnesses (e.g., pneumonia)[299] • Care seeking for children with fever increased with the mother's level of education and wealth quintile[300]	their newborn to the facility for care at the first sign of illness
For malaria, seek and receive prompt and appropriate care at a health	***Knowledge:*** • As knowledge of malaria medicines (p<.001), causes of malaria (p<.05), and comprehensive malaria knowledge (p<.05) improves, respondents were more likely to report seeking appropriate care for a child with fever[301]	***Caregivers of children <5*** • Increase in the percentage of caregivers who believe that the health facility is the first place they should take a sick child

[xv] Likely due to conflicting caregiver responsibilities

facility for yourself or a child with high fever, including testing with a rapid diagnostic test (RDT) to confirm malaria before initiating treatment Focus: Increased demand and action	• Convulsions are not well associated with a high fever[302] • Caregivers have high levels of knowledge of prevention, diagnosis, and treatment (uncomplicated malaria), but differing views about the cause and symptoms of severe malaria[303] • Perceptions that some symptoms resemble a urinary tract infection or typhoid - self-diagnosis could lead to the wrong choice of medications[304] ***Motivation:*** • *Beliefs:* Malaria is caused by witchcraft and can only be healed by traditional healers, only certain people like fishermen/travelers get malaria[305]; Concern over treatment side-effects, uncertainty about effectiveness can lead to self-medication with herbs[306]; Perceived severity of symptoms, increased susceptibility to malaria triggers need for test among adults[307] • *Attitudes:* As favorable attitudes towards proven malaria treatments improve, respondents were more likely to report seeking appropriate care for a child with fever ($p<.06$) [308]; Malaria is seen as an inconvenience, families have other priorities[309]; Mothers who present "late" are seen by health staff as uneducated, intellectually incapable, and lazy[310] • *Intention:* Those who had sought care for a <5 child with a fever were more likely than those who had not to report an intention to do so again in the future ($p<.05$)[311] ***Ability to Act:*** • *Self-efficacy:* Women understand the risks of malaria and some are empowered to protect them and their families[312] • *Access:* Children living ≥5 km from the nearest facility are 2x as likely to have delays in being taken to a facility than those living closer[313]; For children under <5 five, most (53%) sought advice/treatment from 'other sources', 26% from Accredited Drug Dispensing Outlets, and 24% from a pharmacy. 34% sought advice/treatment from the public sector (e.g. health centers (23%))[314]; Poor patient/provider relationships, unavailability of medicine, and costs for treatments are barriers and motivate alternative self-care[315]; Malaria self-treatment is a common practice among adults. The majority self-medicate with a painkiller initially. The persistence/ worsening of symptoms prompts consideration of other self-care options[316]; malarial medicines[317]. Self-treatment with anti-malarial monotherapy is common, motivated by perceived effectiveness and availability[318]' Health facilities have negative associations (e.g., not getting enough attention, waiting)[319]; Accessibility of private lab facilities and drug shops motivates their use for malaria tests and obtaining anti-malarials.	• Increase in the percentage of caregivers who believe there is a heightened risk of malaria for children under five • Increase in the percentage of caregivers with comprehensive and correct knowledge of malaria causes, prevention, symptoms, and treatment • Increase in the percentage of caregivers who intend to take a sick child with fever to the health facility

	Norms: • *Gender norms:* Febrile children from households headed by female caretakers have almost 3x higher odds of being taken to a health facility vs. households headed by men[320]; Treatment decisions are not with mothers, but male family members. It is women who are blamed for not seeking appropriate, timely treatment[321] • *Socio-cultural norms:* Caretakers tend to rely on traditional sociocultural practices to treat convulsions associated with severe malaria in children and do not seek care at facilities, delaying prompt management of the disease[322]; While nearly all caregivers reported attending biomedical facilities to treat children with fever (98%), many stated convulsions are best treated by traditional healers (43%)[323] **Facilitators:** • As exposure to messages around ITN use (p<.05) and prompt care seeking for children (p<.07) improves, respondents were more likely to report seeking appropriate care for a child with fever[324]. • High knowledge fever is a sign of malaria for a young child (77% women, 72% men age 15-49)[325] • Febrile children with caretakers exposed to mass media have 2x higher odds of going to a facility vs. those not exposed[326] • A high percentage of women (90%) and men (81%) reported ACTs can be obtained at the nearest health facility or pharmacy[327]	
Seek and receive a full course of timely vaccinations for infants and children under two Focus: Increased demand and action	***Knowledge:*** • Low and delayed vaccination coverage associated with mother's education level[328] • Low uptake of measles vaccine associated with caretaker's lack of knowledge on the purpose of supplementary measles vaccine, and timing of the age when child should receive the vaccine[329] • Children in wealthier households were more likely to have completed all basic vaccinations[330] • Children born in a health facility were more likely to have received all vaccinations[331] ***Motivation:*** • *Attitudes:* Mothers who were satisfied with vaccination services were more likely to have children who had completed all vaccinations[332] ***Ability to Act:*** • *Access:* Distance to health facility associated with vaccination coverage (children living >5km from health facility less likely to receive full course of vaccinations)[333]	*Additional insights gathering is needed for this behavior. Illustrative objectives include:* ***Caregivers of children <5*** • Increase in the percentage of caregivers with knowledge of when and why to vaccinate their children • Increase in the percentage of caregivers who believe that completing a full course of vaccinations is one important way that they can nurture their child

Caregiving <5

Promoted Behavior	Key Promise	Illustrative Messages
• Sleep under an ITN every night, including children under five • After a live birth, use an MCM to avoid pregnancy for at least 24 months • Exclusively breastfeed your infant for six months after birth • Seek and receive prompt and appropriate care at first sign of newborn and childhood illness • For malaria, seek and receive prompt and appropriate care at the health facility for yourself or a child under five with a high fever, including use of a rapid diagnostic test (RDT) to confirm malaria • Seek and receive a full course of timely vaccinations for infants and children under two	Parents who take time to prevent and treat illness, ensuring their children have the best care are more likely to enjoy the good life, one filled with fun, happiness, and security. A healthy child can do better in school, achieve a better life and provide for parents when they are old.	You are being the best parent and caregiver possible when you take your child to the clinic at the first signs of illness Remember, malaria is a very serious illness for young children With some practice, talking to your partner about MCMs will become easier MCMs, including long-term methods, are safe and have no effect on your future fertility. Many women like you are using them. If you experience uncomfortable side effects, talk with your health care provider. If I take steps to prevent and treat malaria, I will be a great parent who loves and protects my child's future Health care providers are your neighbors, with services and information for a vibrant future for your child When you bring your child to the health facility when they are sick/for HIV testing/for immunization, you will be recognized by health workers, family, and your community as caring and responsible You will have peace of mind because you are being proactive and preventing costlier problems down the road; you will get the right diagnosis and services are free You will be recognized by husbands and partners as smart and responsible (and a good wife and mother for those who are married) You will know you are nurturing your families' health and future By taking steps at home and seeking care at the facility, you will have healthier children who will bring you respect in the community You will gain status in the community as someone who is providing for a strong and healthy family

Activity and Materials Package for the Caregiving <5 Package

Under the NAWEZA brand, the focus for this package is on accessing care at critical times (e.g., in response to illness or for prevention) and adoption of healthy behaviors at home that set the foundation for a strong and healthy family (e.g., EBF and use of an MCM to achieve desired fertility objectives). A mix of channels are used, from mass media, to set normative behaviors and model early adopters, to community and interpersonal channels to facilitate dialog, address barriers, and build skills and confidence in carrying out promoted behaviors. Mobilization and community advocacy support an enabling environment for change (e.g. in support of BF mothers). During rainy season, targeted malaria activities are implemented. In five FP priority

regions (high fertility, low MCM uptake), intensified activities promoting MCM uptake are implemented (see further details under Intensified Programming for FP section to follow).

	ITN	MCM	EBF	Seek Care Newborn Illness	Seek Care <5 with Fever	Immunization
Mass Media						
Radio show	X	X	X	X	X	X
Radio spots	X	X	X	X		X
Community radio	X	X	X	X	X	X
Health expert interview		X	X	X		X
DJ presenter mentions	X	X	X	X		X
Social media	X	X	X	X	X	X
SMS	X	X	X	X	X	X
Elimu ya Afya[xvi]	X	X	X			
Billboards	X					
Mid-media						
Community theater	X	X	X	X	X	X
Edutainment events	X	X		X		
IPC						
Household & facility counseling*	X	X	X	X	X	X
Mother meet-ups	X	X	X	X		X
Small group dialog	X	X	X	X		X
Community /religious leader mobilization	X	X		X		X
Orientations						
Providers	X	X	X	X	X	X
IPs	X	X	X	X	X	X

***Including timed household visits implemented by USAID Tulonge Afya as well as counseling** implemented by other USG implementing partners with USAID Tulonge Afya support tools.

Activities and Supporting Media/Materials

- Radio show: A long-running radio show, NAWEZA, showcases real life stories that are related to the behavior and norm change priorities supported through the Life Stage packages. Stories showcase how audiences have addressed and overcome key barriers of these behaviors
- Radio spots are aired nationally and regionally for select behaviors with priority emphasis on those likely to affect multiple health outcomes. In addition to spots on noted health topics, radio spots have been developed to promote male engagement.
- Community radio localizes content, engages communities in dialog, and recognizes community members' success in achieving healthy behaviors. Materials to support these programs include:
    - Community Radio Guide
    - Community Radio Training
    - Supplementary Topic Guides
- Social media targets first time mothers in urban and peri urban areas using Facebook, Instagram, and WhatsApp.
- SMS is used to send supportive messages; Elimu ya Afya is a pull SMS service which incorporates messages across health areas.
- Billboards are used in strategic locations to emphasize key calls to action.
- Community theater is used to engage audiences in reflection and dialog around key behavioral priorities and to generate community-driven solutions to their uptake. Tools to support this include:
    - Community Theater Guide

[xvi] This is the former m4RH program that has not been adapted by the GOT and will include all health areas

    - Community Theater Scripts
- Edutainment events leverage existing community platforms that have traction with target audiences and are linked with service provision.
- Timed household counseling visits are implemented by USAID Tulonge Afya-supported CHWs to reach mothers of children <6 months at key time points. Visits incorporate discussion and counseling related to all health areas, as well as linkage and referral to care.
- Household and facility level counseling is conducted by CHWs and community volunteers (by other USG IPs, such as USAID Boresha Afya) using a counseling tool produced by USAID Tulonge Afya that incorporates all health areas
- Community dialog aims to build skills and confidence, identifies solutions to barriers, and creates a sense of support among peers using an interactive community dialog toolkit.
- Mother meet-ups are entertaining group events incorporating music, games, testimonials, and discussion to provide new mothers with opportunities to discuss priority behaviors and to generate social support for their adoption
- Community/religious leader mobilization supports uptake and attention for priority behaviors and/or addresses barriers to care using a Community and Religious Leader Mobilization Guide.
- Orientations for providers and implementing partners on use of the Life Stage packages using Service Provider Orientations, Provider Do/Don't Do Counseling Videos (later years), Life Stage Package Implementation Guide. An expanded set of provider-focused tools and activities are described under the PBC section
- Other print materials:
    - NAWEZA Actions for a Healthy Baby and Child
    - MCM invitation cards
    - Appointment/key milestones reminder tool
    - Key milestones facility poster (e.g. When to come for PNC and Well Child visits)
    - Posters, brochures, billboards, etc.

Targeted and Other SBC Campaigns

Over the life of this Strategy, it is expected that needs will emerge for campaigns that do not fall within the packages described within this document for adult audiences. New packages will be developed to align these as vertical campaigns under the NAWEZA brand, as appropriate. It is envisioned that these will include short/mini and long-running campaigns that will be implemented in a primarily vertical manner (e.g for TB separate from *Furaha Yangu* or VMMC for adult audiences), though any opportunities for integration with USAID Tulonge Afya's other focal health areas will be maximized.

This strategy will be updated annually to incorporate specific behavior, normative, and communication objectives; determinants; audiences; and activities for campaigns that fall under the Adult Platform as they are identified with partners, the GOT, and USAID.

Furaha Yangu

In Year One, the GOT rolled out the *Furaha Yangu* campaign to increase awareness of the GOT's new Test and Treat policy and to reduce stigma around HIV testing and PLHIV. As the Adult Strategy has been implemented, *Furaha Yangu* SBC activities have been continued under it as a sub-brand. Younger adolescent girls and young women as well as adolescent boys at risk for HIV will be primarily reached through the GOT's Youth Platform but will also benefit from reinforcing messages and activities implemented under subsequent phases of *Furaha Yangu* as part of the Adult Platform.

Key Primary and Secondary Audiences:

Targeted Audiences at Greater Risk for HIV and TB, including Men (ages 18-24: Amani, 25-49: Shukuru) and in higher risk occupations[xvii]), Pregnant Women (Asunta)[xviii], Key Populations, and Caregivers of HIV Exposed Children (Hulda, Romana); PLHIV (Shukuru, Assunta); People with TB (Kilomo, Mwasiti); General Population[xix]

Desired Behaviors	Barriers and Facilitators	Key Communication Objectives
Go for HIV testing and counseling if at risk, and receive results Focus: Increased demand, action, and advocating	***Knowledge:*** • Those who tested for HIV (last 6 months) were more likely (p<.05) to report knowledge that condoms prevent HIV than those who had not tested and that circumcised men are less likely to acquire HIV (p<.05)[334] • Health care workers and clients have many questions about ART[335] ***Motivation:*** • *Beliefs:* Those who tested for HIV (last 6 months) were more likely to report (p<.0001) a belief that it's better to know your status than not to know it and have positive attitudes (p<.001) towards ART[336]; Overarching fear of HIV+ diagnosis (loss of control, not achieving dreams) – what will life be like after the test?)[337]; fear of losing support of loved ones/ not belonging[338]; Pregnant Women: Fear of physical violence and being assumed unfaithful[339]; Caregivers of an HIV exposed child: Fear of result for child or that HIV+ test will give away their status[340]; Concerned about side effects/safety of ART on infants and themselves[341]; Belief that HIV tests from small clinics are less accurate and must be confirmed[342] • *Intention:* As intention to take ART if tested HIV+ improved, respondents were more likely to report HIV testing (p<.05)[343] • *Attitudes:* Low risk perception[344]; Asymptomatic HIV+ pregnant women may feel ART during pre-natal care is unnecessary[345] ***Ability to Act:*** • *Dialog:* As dialog about HIV testing (last 6 months) improved, respondents were more likely to report HIV testing (p<.0001) [346]; Pregnant women: Most participants indicated they were comfortable talking with their partner about prevention of mother-to-child services (PMTCT) services (yet only 36.5% of pregnant women have discussed PMTCT in the last 6	***General population[i] and targeted audience segments at risk for HIV*** • Increase in the percentage of target audience who know that ART is immediately available after testing positive for HIV ***Targeted audience segments at risk for HIV*** • Increase in the percentage of target audience with positive attitudes towards HIV testing • Increase in the percentage of target audiences with increased HIV risk perception • Increase in the percentage of target audience who intend to test for HIV

[xvii] Transportation, mining, construction, plantation, forestry, fishing, informal eateries on transport corridors, local brewers, and local bars

[xviii] Will have some overlap with the Pregnancy Package

[xix] Towards treatment normalization and stigma reduction as well as awareness of the new Test and Treat policy

	months). Younger pregnant women were less likely to have discussed PMTCT[347] • *Stigma and discrimination* (community and facility-level)[348]**;** Confidentiality is a critical factor for HIV testing and counseling (HTC) uptake; larger hospitals preferred for confidentiality[349] **;** Most prefer a provider not from their community[350] • *Access:* Transport costs are a notable barrier to HTC[351]; Logistical concerns of post-natal infant ART adherence[352]; Economic concerns[353]; Rural women are less able to access care[354] • *Support:* Partner support may increase adherence to ART[355]; Lack of support for young mothers and those without partners[356] ***Norms:*** • *Gender norms:* Participants with high support for gender equitable norms are.782 times as likely to test for HIV in the future than an individual with lower support for gender equitable norms[357]; Belief that men must be strong and infallible; to admit they have a health issue would be shameful[358]; Health clinics are regarded as a place where women go for pregnancy/child birth, not a place for men to seek health advice or services[359]; Young HIV+ pregnant women commonly face discrimination in health facilities[360] **Facilitators:** • Those who tested for HIV in the last six months were significantly more likely to have intention to test (**p<.0001, OR 12.13**), be aware of treatment available (**p<.0001, OR 2.816**), and to have a positive attitude towards HIV testing (**p<.0001, OR 2.615**) than those who had not tested; they were also more likely to have comprehensive knowledge around the spread of HIV (p<.0001, OR 1.995). • As exposure to HIV testing messages improved, respondents were more likely to report HIV testing in the last six months (p<.0001)[361]	
If HIV positive, enroll in care, initiate ART, and follow health care worker guidance Focus: Increased demand and action	***Knowledge:*** • Health care workers and clients have many questions about ART[362] ***Ability to Act:*** • *Beliefs:* Asymptomatic patients are less likely to seek prompt initiation of care[363] • *Access:* Clients often encounter challenges during their initial visit such as being told to leave and return on another day due to restricted opening hours, limited capacity for enrollment, and shortages of providers[364]; Many HTC facilities are not co-located or close to care and treatment centers[365]; Substance use; ART knowledge and attitudes; peer and partner support; stigma and discrimination; wait times and distance; and food security and poverty all influence linkage and	***PLHIV*** • Increase in the percentage of PLHIV who believe that initiating ART will allow them to control their HIV symptoms • Increase in the percentage of PLHIV who believe that staying in care and initiating ART allows them to be in control of their health and life ***HIV+ pregnant women and their partners (link with PMTCT)*** • Increase in the percentage of HIV+ pregnant women and their

	retention in care, ART initiation, and ART adherence for FSW[366] • *Stigma & discrimination:* FSW frequently experience stigma, discrimination, and violence and may face additional stigma and discrimination when attending ANC visits without a male partner[367]; illegality of risk behavior **Facilitators:** • A key facilitator to prompting linkage to care is severe illness at the time of the HIV diagnosis[368]	partners who believe that HIV is a manageable chronic condition for them and their baby •
Ask to be started on TLD when enrolling on ART Focus: Increased demand, action, and advocating	***Knowledge:*** • Clients are unaware of TLD and that it is now the preferred first-line ARV treatment[369] ***Motivation:*** • *Beliefs:* Perception that TLD isn't appropriate for women of reproductive age[370]	***PLHIV*** • Increase in the percentage of PLHIV who know that TLD is the preferred first-line ARV treatment • Percentage of female PLHIV who believe that TLD is safe and appropriate for them
Take ART regularly, as prescribed and go for routine viral load monitoring Focus: Increased action and maintenance	***Knowledge:*** • Health care workers and clients have many questions about ART[371] ***Motivation:*** • *Beliefs:* Perceived susceptibility to HIV-related illnesses is an important factor influencing clinic attendance[372]; New mothers may be concerned about side effects/safety of ART on infants and themselves[373] • *Attitudes:* Belief that missing appointments for HIV treatment is inevitable - competing priorities (e.g.travel, caring for sick relative, funerals)[374]. ***Ability to Act:*** • *Access:* Many PLHIV note poor treatment by HCW as a deterrent for adhering to a treatment schedule[375]; Distance from clinics[376,377]; Cost of treatment and associated expenses (e.g., transport and other indirect medical tests is a barrier to consistent access to HIV treatment[378]; Lack of food and substance abuse linked to adherence difficulty for FSW[379]; Inability to take time away from work to attend clinic visits[380]; Frequent travel away from their community for work limits ability to attend appointments and access ART[381] • *Stigma & discrimination:* Perceived social stigma is a barrier to retention[382,383] ; Provider stigma for FSW, MSM, and PWID reduces demand for treatment[384] ***Norms:*** • *Socio-cultural norms:* Many seek faith healing instead of (or prior to) accessing facility-based care and treatment[385] **Facilitators:**	***PLHIV*** • Increase in the percentage of target audiences who believe they can live a normal and healthy life by regularly taking ART and staying in care • Increase in the percentage of target audiences who believe they can protect their partners and relationship by regularly taking ART and staying in care • Increase in the percentage of target audiences who believe that failing to take their ART regularly is serious

	• Respondents that had at least a primary education level were three times more likely to be highly knowledgeable about ART[386] • FSW have found carrying ARVs with them helps adherence as they often do not sleep in their own homes every night[387] • Belief that missing a dose of ART or missing a clinic appointment is serious[388]	
For HIV+ women, go for cervical cancer screening Focus: Increased demand and action	***Knowledge:*** • Low levels of knowledge about cervical cancer, particularly around causes, risk factors, prevention, and treatment, whereas knowledge of symptoms is somewhat higher[389,390] ***Motivation:*** • *Belief:* Many women fear cervical cancer screening because they see a positive diagnosis as a death sentence or believe that it means they cannot get pregnant in future[391]; Screening only needs to take place once you have symptoms; there are no benefits to early detection *"…in the streets there is a belief that if you know early you have cancer, you die early."*[392] ***Ability to Act:*** • *Access:* Cost of travel to health facility[393] ***Norms:*** • *Socio-cultural norms:* Women who are diagnosed with cervical cancer are often stigmatized in the community and abandoned by their partner because they are seen as worthless when they cannot have sexual relations or due to the belief that cervical cancer is caused by unfaithfulness[394] **Facilitators:** • Knowledge that early screening and detection leads to better outcomes[395,396] • Positive attitudes toward cervical cancer screening[397] • Older women are more likely to have accessed screening than younger women[398,399]	***HIV+ women*** • Increase in the percentage of HIV+ women who believe that early detection of cervical cancer leads to better outcomes ***HIV+ women and their partners*** • Increase in the percentage of HIV+ women and their partners who have comprehensive and correct knowledge of cervical cancer (causes, risk factors, symptoms, prevention, and treatment)
Seek care from a qualified TB provider for a cough that persists for more than two weeks Focus: Increased demand, action, and advocacy *NOTE: this behavior will be promoted as	***Knowledge:*** • Those who sought treatment for a persistent cough lasting (>2 weeks) were more likely to report correct knowledge of TB prevention, symptoms, and treatment ($p<.0001$) than those who had not sought services[400]. As TB knowledge ($p<.01$) and knowledge of TB/HIV coinfection ($p<.05$) improves, respondents were more likely to report seeking care for a cough lasting >2 weeks[xx],[401]. • Lack of knowledge about TB and HIV, the importance of early diagnosis and the availability of free services for both TB and HIV[402] • Cough not perceived as a serious symptom of a severe illness like TB[403] • Community knowledge on the cause of TB poor, particularly in rural populations[404]	***Targeted populations at greater risk for TB*** • Increase in the percentage of target audiences with comprehensive and correct knowledge of TB • Increase in the percentage of target audiences who intend to seek care for a cough lasting more than two weeks • Increase in the percentage of target audiences who feel comfortable discussing TB testing and treatment with others

[xx] Preliminary analysis from a Stepwise regression

part of *Furaha Yangu* as well as directly under the NAWEZA brand through mini campaigns unlinked to HIV and Test and Treat	• Education level and knowledge of TB results in delayed care seeking and testing for TB[405] ***Motivation:*** • *Beliefs:* People believe smoking cigarettes, witchcraft, inheritance and drinking of un-boiled milk or milk contaminated with cow's hair cause TB[406] • *Support:* As likeliness to advise a friend to receive treatment (p<.1) improves, respondents were more likely to report seeking care for a cough lasting >2 weeks[407]; Fear of being considered as a "sick" person, because this could derail plans for business success and a happy marriage[408]; Positive community perception and its management is a prerequisite to early treatment seeking[409] ***Ability to Act:*** • *Dialog:* Those who sought TB screening and testing for a cough lasting >2 weeks were more likely (p<.05) to express comfort in discussing TB treatment with those in their community[410]and more likely to report (p<.05) discussing TB testing and treatment in the last six months than those who had not sought treatment. They also expressed more likeliness to be screened for a future cough (p<.05)[411] • *Access:* Distance from a facility is closely associated with delayed care seeking at the onset of symptoms[412] ***Norms:*** • *Socio-cultural norms:* Self-medication is the preferred method of treatment, whereas health facility consultation is not seen as a primary course of action upon symptomatic illness[413] • *Gender norms:* Health clinics are seen as a place where women go for services related to pregnancy and child birth and not a place for men to seek health advice or services[414] **Facilitators:** • As exposure to TB messages and education improves, respondents were more likely to report seeking care for a cough lasting >2 weeks (p<.1-.05)[415]	• Increase in the percentage of <u>target audiences</u> who believe testing at the health facility for TB for a cough lasting more than 2 weeks is important

Furaha Yangu

Promoted Behavior	Key Promise	Illustrative Messages

• Go for HIV testing and counseling if at risk, and receive results • If HIV positive, enroll in care, initiate ART, and follow health care worker guidance • Ask to be started on TLD when enrolling on ART • Take ART regularly as prescribed and go for routine viral load monitoring • For HIV+ women, go for cervical cancer screening • Seek care from a qualified TB provider for a cough that persists for more than 2 weeks	With testing and treatment, men can continue to be respected members of their community Women will be accepted and recognized in the community for seeking testing and treatment With treatment, women can continue to care for their children and be a good wife and mother	You will be seen as a strong leader in the community if you model treatment seeking and adherence. It is a strong man that shows he can. You will find your happiness by taking care of your health. You can have a fuller and positive life if you adhere to all treatments. With ART you can protect your partner and keep your dreams of love, sex, and romance alive ART can bring you peace of mind. ART eliminates fear and dread because you can live a longer life within your community ART allows me to feel accepted ART keeps you strong Go to the facility to test for TB if you have a cough that lasts for more than two weeks to keep your family healthy and secure Men are protecting their families when they seek testing and get early treatment for TB at the health facility

Activity and Material Package for Furaha Yangu

Furaha Yangu includes targeted mass media to generate a norm of care seeking behavior and adherence to drugs; interpersonal programming to develop skills and self-efficacy in health care seeking behavior (including navigating the health system) and adherence, and community mobilization to create an enabling environment for promoted behaviors. The various channels used are mutually reinforcing with consistent messages and clear calls to action under the common framework that crosses over HIV and TB. Phase I of the campaign focused on raising awareness of the GOT's new Test and Treat policy, the availability of ART immediately for anyone who tests positive, and on treatment normalization. Subsequent phases of the campaign include greater strategic targeting of PLHIV and higher-risk groups (men, key and vulnerable populations, caregivers of orphans and vulnerable children) to support personal risk assessments, promote adoption of HIV testing and treatment initiation (including index testing) and adherence behaviors, and to address HIV/TB co-infection through promotion of TB testing. Given the need for targeted approaches to reach these audiences, Furaha Yangu campaign activities have increasingly emphasized community-level SBC approaches, including small group dialog, referrals, and linkages to care, supported by low-level and targeted mass media. These are being further reinforced through use of provider tools and materials to improve the quality of HIV counseling and adherence support.

	HTC	ART Initiation/ Enrollment	Adherence and Viral Load	**Cervical Cancer Screening**	TB Prevention and Care Seeking
Mass Media					

	HTC	ART Initiation/ Enrollment	Adherence and Viral Load	**Cervical Cancer Screening**	TB Prevention and Care Seeking
Radio show	X	X	X	X	X
Radio spots	X				X
Community radio	X	X	X	X	X
Health expert interview	X				X
DJ presenter mentions	X				X
Social media	X	X			
SMS	X	X	X	X	X
Elimu ya Afya[xxi]	X	X	X	X	X
Billboards	X				X
Mid-media					
Community theater	X				X
Edutainment events	X				
IPC					
Household & facility counseling	X	X	X	X	X
Small group dialog	X	X	X	X	X
Community /religious leader mobilization	X	X	X	X	X
Orientations					
Providers	X	X	X	X	X
IPs	X	X	X	X	X

Activities and Supporting Media/Materials

- Radio show: A long-running radio show, NAWEZA, showcases real life stories that are related to the behavior and norm change priorities supported under the campaign. Stories showcase how audiences have addressed and overcome key barriers of these behaviors
- Radio spots are aired nationally and regionally for select behaviors with priority emphasis on those likely to address knowledge needs (e.g. of immediate ART) and determinants affecting HIV testing, such as stigma and discrimination. Spots are aired during programs and time slots with high listenership among targeted audiences, particularly men.
- Community radio supports regional and national radio. Materials to support community radio programs include:
    - Community Radio Guide
    - Community Radio Training
    - Supplementary Topic Guides
- Social media targets audiences in urban and peri urban areas using Facebook, Instagram, and WhatsApp
- SMS is used to send supportive messages; Elimu ya Afya is a pull SMS service which incorporates messages across health areas.
- Billboards are used in strategic locations (e.g. near mining communities and hotspots) to emphasize key calls to action.
- Community theater is used to engage audiences in reflection and dialog around the key behavioral and normative priorities and to generate community-driven solutions to their uptake. Materials to support community theater performances include:
    - Community Theater Guide
    - Community Theater Scripts
- Edutainment events leverage existing community platforms that have traction with target audiences and are with service provision
- Small group dialog sessions with high-risk audiences are conducted by CHWs and community volunteers in hot spot locations using interactive toolkits to address barriers to HIV testing

[xxi] This is the former m4RH program that has not been adapted by the GOT and will include all health areas

HTC	ART Initiation/ Enrollment	Adherence and Viral Load	**Cervical Cancer Screening**	TB Prevention and Care Seeking

- In partnership with the National Association of People Living with HIV/AIDS (NACOPHA), one-on-one and small group counseling and discussion sessions are conducted with PLHIV using job aids that incorporate behaviors across the care and treatment cascade
- Household and facility level counseling is conducted by CHWs and community volunteers using job aids that incorporate all health areas and on targeted behaviors as appropriate
    - Integrated counseling tool for use at facility (including for post-test counseling on ART initiation and enrollment and on partner notification and index testing) and community
    - Risk profiling counseling tool to identify and guide counseling for PLHIV clients at higher risk of LTFU
    - KVP-tailored counseling tool
- Community dialog aims to build skills and confidence, identify solutions to barriers, and create a sense of support among peers. These include dialogs in PLHIV peer support groups using an interactive community dialog toolkit
- Community/religious leader mobilization supports uptake and attention for priority behaviors and addresses barriers to care using a Community and Religious Leader Mobilization Guide.
- Orientations for providers and implementing partners on using campaign materials and providing client-centered care through a Service Provider Orientation, Provider Do/Don't Do Counseling Videos , Campaign Package Implementation Guide. An expanded set of provider-focused tools and activities are described under the PBC section
- Other print materials:
    - HIV testing invitation/referral cards
    - Appointment/key milestones reminder tool
    - Low-literacy print materials and job aids around treatment literacy
    - Materials/posters on index testing and partner notification

PBC

In Year One, the Adult Strategy integrated health providers as audiences within each Life Stage package and campaign, with provider-focused communication objectives established in support of the priority behaviors. An initial set of activities and materials addressing providers were designed and implemented in FY18 and FY19. This implementation experience highlighted the need and potential for a more substantive focus on health providers to support achievement of NAWEZA behavioral objectives. Beginning in FY20, PBC objectives will be addressed through a larger set of activities and materials, developed in close partnership with service delivery implementing partners. These will focus on "light-touch" approaches and other programming tweaks that can be effectively integrated within existing programming. Importantly, the provider behavior change objectives are directly aligned with NAWEZA priority behaviors, to ensure provider-focused activities contribute to broader NAWEZA aims and objectives.

NAWEZA Desired Behavior	**Supporting Provider Behaviors**
All care-seeking behaviors[xxii]	Provide respectful, quality, and confidential services without bias, regardless of client age, sex,

[xxiixxii] Provision of respectful, quality and confidential services will support adoption of the following care-seeking behaviors among NAWEZA audiences: Go early, attend, and complete more than 4 ANC visits (8 contacts are desired); Take IPTp-3 during ANC visits; Attend PMTCT services and take ART as prescribed if HIV+; Attend a health facility for delivery; Attend PNC visits and seek prompt and appropriate care at the health facility upon the first sight of post-partum danger signs; Bring your infant to the facility for an early visit at 4-6 weeks, and for HIV testing if mother is positive or status unknown; Seek and receive prompt and appropriate

(Pregnancy & Childbirth, Parenting & Caregiving, Furaha Yangu)	marital status, HIV status, or male partner accompaniment
Initiate BF within an hour of birth *(Pregnancy & Childbirth)*	Help new mothers initiate breast feeding within an hour of birth Show new mothers how to breastfeed and how to maintain lactation, even if they are separated from their baby
Talk with your health care provider about PPFP options *(Pregnancy & Childbirth, Parenting & Caregiving)*	Counsel pregnant and postnatal women on the range of FP options available to them and possible side effects without judgment and regardless of age or parity
Attend PNC visits and seek prompt and appropriate care at the health facility upon the first sight of post-partum danger signs *(Pregnancy & Childbirth)*	Provide quality counseling on postpartum danger signs and postpartum care visits to newly delivered women
EBF your infant for six months after birth *(Parenting & Caregiving)*	Provide quality, action-oriented counseling to support and empower mothers to overcome challenges to breast feeding Show new mothers how to breastfeed and how to maintain lactation, even if they are separated from their baby
For malaria, seek and receive prompt and appropriate care at the health facility for yourself or a child under five with a high fever, including use of an RDT to confirm malaria *(Parenting & Caregiving)*	Use an RDT to confirm a malaria diagnosis before giving treatment

Activity and Material Package for Health Providers

The focus of the NAWEZA PBC activities will be on provision of respectful client-centered care; quality counseling (e.g. non-biased FP counseling, support for EBF); and adherence to clinical protocols (e.g. counseling women on the full range of FP options, supporting early initiation of BF, use of RDT before treating fever). A mix of approaches will be used, including modeling and peer-to-peer support approaches to highlight positive deviants, facilitate dialog, and shift norms. Self-assessments will empower providers to identify their own issues and seek their own solutions. Pledges and commitments will generate public accountability for behavior change and shift providers' self-perception (e.g. *I CAN* provide all of my clients with the FP services they desire). Non-financial incentives and rewards (e.g. community recognition through community programs and media) will be used to motivate providers and to recognize and elevate those who adopt the desired behaviors. Quality-based approaches will engage clients in

care at first sign of newborn and childhood illness; Seek and receive a full course of timely vaccinations for infants and children under two; Go for HIV testing and counseling if at risk, and receive results; If HIV positive, enroll in care, initiate ART, and follow health care worker guidance; Ask to be started on TLD when enrolling on ART; Take ART regularly, as prescribed, and go for routine viral load monitoring; For HIV+ women, go for cervical cancer screening; Seek care from a qualified TB provider for a cough that persists for more than two weeks

identifying high-performing facilities; routine sharing of quality metrics will promote competition between facilities. Short virtual trainings, which can be embedded within existing service delivery partner trainings or offered as standalone sessions, will build providers' skills and self-efficacy. Emphasis will be placed on strategic activities and materials that can easily be integrated within existing service delivery partner programming. All PBC activities will seek to take a supportive approach that will engage health care providers as solutions, rather than barriers, to behavior change.

	Respectful Care	BF Initiation	EBF Support	FP Counseling	Postpartum Counseling	Malaria Diagnosis
Modeling						
Do/ Don't Do Videos	X	X	X	X	X	X
Provider testimonials	X	X	X	X	X	X
Self-assessments	X	X	X	X	X	X
Pledges/ Commitments	X	X	X	X	X	X
Incentives						
Community recognition	X	X	X		X	
Management recognition	X	X	X		X	
Quality Facilities	X	X	X	X	X	X
Virtual Trainings	X			X	X	
Print Materials						
Job aids	X	X	X	X	X	
Posters	X	X	X	X		
Brochures/flyers	X					

Activities and Supporting Materials

- Do/ Don't Do Videos: Short role play videos depicting positive and negative provider-client interactions will be used to demonstrate desired behaviors. Associated prompt questions will be provided to stimulate discussion (for group use) and reflection (for individual use) on the role play examples, and how providers can adopt the "do" actions. Videos will be used during existing provider training sessions and disseminated as part of ongoing professional development opportunities and through existing channels, such as WhatsApp groups for providers managed by service delivery implementing partners
- Provider testimonials: With the support of community members, high-performing providers will be identified and asked to provide testimonials about their work, their motivations, and how they feel about serving their community. Testimonials will be adapted into a variety of formats, including short (1-2 minute) videos and audio clips to be disseminated through digital and social media and community radio, and in print materials, such as existing newsletters and brochures
- Self-assessments: Self-administered guides with prompt questions will allow providers to examine their own knowledge, attitudes, biases, and behaviors. Assessment tools will support providers to explore how identified issues impact the care they provide and to problem-solve solutions.
- Pledges/ Commitments: Building on the *Furaha Yangu* provider commitment pin implemented in FY18, additional public pledge and commitment opportunities will be integrated within existing provider

	Respectful Care	BF Initiation	EBF Support	FP Counseling	Postpartum Counseling	Malaria Diagnosis

trainings and roll-out of new NAWEZA campaigns and materials. This might include pledge cards, commitment walls/boards within facilities, or other physical commitment symbols.

- Incentives: Audience consultations identified recognition as a primary emotional driver for providers. Therefore, opportunities for recognizing and celebrating high-performing providers will be implemented as incentives. This will include community recognition through provider spotlights during community radio programming, provider celebrations integrated within community theater and edutainment events, and "Top Provider" profiles highlighted through social media. Opportunities for integrating formal non-financial recognition within existing management and incentive structures (e.g. certificates, letters from managers/senior Government officials) will also be explored with service delivery IPs and GOT staff.
- Quality Facilities: Working with service delivery partners, facility staff, and community members, a small set of quality metrics will be identified for tracking on a routine basis. These metrics will be posted publicly in all facilities within the project's 29 Enhanced Districts to allow for comparison between facilities, to promote competition and recognition of high performers, and to demonstrate shifting norms around provision of quality client care.
- Virtual Trainings: Short audiovisual training sessions will be developed for select behaviors, with priority emphasis on those that relate to client counseling and behavioral negotiation. These may be offered as part of existing training programs or as standalone sessions.
- Print materials, including job aids, will be developed to support and reinforce select behaviors.

Implementation of the Strategy

The Adult Strategy is implemented within the systems and structures of the MOHCDGEC and other ministry bodies at regional and district levels, as well as through a range of IPs to ensure the strategy meets audience needs, addresses priority health issues, is delivered at scale, and is aligned with service delivery considerations.

Geographic Targeting

USAID Tulonge Afya, within its implementation, geographically targets SBC activities. The level and intensity of programming supported under the Adult Platform varies based on locations that have been strategically prioritized in coordination with epidemiolocal need and GOT and USAID presence and priority. The project offers an Essential SBC Package to USG IPs across Tanzania with a focus on the 19 USAID Boresha Afya regions. An Enhanced SBC Package is offered in 29 Enhanced Districts.

Zone	Number	Districts
North/Central	8	Arusha CC, Arusha DC, **Igunga DC**, **Nzega DC, Tabora MC, Uyui DC,** Singida MC, Manyoni DC
Southern	8	**Iringa MC, Kilolo DC**, Masasi DC, **Mufindi DC**, Newela DC, **Njombe TC, Njombe DC, Wanging'ombe DC**
Lake/Western	13	Bukoba DC, Geita DC**, Geita TC**, **Kahama TC**, Kasulu DC, Kigoma Ujiji MC, Muleba DC, Musoma MC, **Nyamagana MC,** Rorya DC, **Sengerema DC, Shinyanga MC,** Shinyanga DC

Note: The President's Malaria Initiation focal areas receiving Enhanced District level support in year one includes; Nyamagana MC, Sengerema DC, Shinyanga MC and Shinyanga DC.

Overall, the strategy is implemented in three zones in Tanzania, North Central, Southern, Lake/Western, with national level media and regional radio. Each zone has specific cultural and health issues. These are taken into consideration when working at the Regional and District level to tailor the strategy to local priorities.

USAID Tulonge Afya Programming Support Intensity

Activity	Essential SBCC Package	Enhanced SBCC Package
National platform	X	X
Regionalized radio and messaging	X	X
Community radio and theatre		X
Social media	X	X
mHealth	X	X
SBC technical assistance and tools	X	X
CHW job aids	X	X
IPC materials	X	X
Opportunistic activities	X	X
Leveraged activities with other implementers	X	X
District mobilization and sensitization campaigns		X

Joint planning and small grants	X

Intensified Programming for Family Planning

In consultation with USAID and the GOT, USAID Tulonge Afya identified a need for intensified programming in support of FP objectives beginning in FY20. The project will focus this intensified programming in Enhanced Districts in five priority regions with low FP uptake and high teenage pregnancy rates (Geita, Kigoma, Mwanza, Tabora, and Shinyanga). In these Enhanced Districts the project will expand and deepen its FP coverage within community-level SBC activities. This will include increased saturation of FP programming in these districts (e.g. re-airing of FP NAWEZA anchor show episodes and radio spots on community radio stations, distribution of greater numbers of FP print materials, implementation of additional FP-focused small group dialogues and mother meet-ups) and regionalization of select FP materials and activities to address specific barriers to priority FP behaviors. The project will also work with FP service delivery partners implementing in these districts to offer pop-up FP counseling and services in coordination with small group sessions, mother meet-ups, and community theater events.

Collaborating Partners

This strategy is implemented by and with the GOT and a variety of IPs. These include USG implementers to address supply and demand-side considerations and coordination; local partners who directly implement components of the strategy; GOT partners who support and provide oversight; and audiences themselves, who are critically engaged to serve as advocates for promoted behaviors in their community and to actively engage in the design and delivery of SBC activities.

Multiple partners are engaged at different levels, from development to implementation of the Adult Platform. The table below describes the role and relationship of each partner during entire project period.

Partners category	Institution	Role and working relation
GOT Partners	MOHCDGEC	At national level, the MOHCDGEC works with USAID Tulonge Afya to support, guide and endorse concepts and the campaign brand for the Adult Platform
	PORALG	PORALG facilitates smooth engagement with local government authorities and at regional and district level on concepts and materials pretesting, campaign implementation and supportive supervision
	TACAIDS	TACAIDS is the key partner on coordinating HIV/AIDS multi-sectoral engagement. It supports *Furaha Yangu* campaign enrollment, execution, and scale up in the regions and sectors beyond USAID Tulonge Afya's geographic scope.
USG Partners	USAID Boresha Afya - Jhpiego	Participates in campaign material development, launches, and implementation. Uses campaign service provider counselling cards and targeted SBC materials

		to promote respectful maternity care services and client-centered care services.
	USAID Boresha Afya - EGPAF	Participates in the Adult Platform, including campaign development, launch, and implementation.
	USAID Boresha Afya – Deloitte	Is supported through experiential marketing and radio media to increase the uptake of the FP outreach activities, as well as capacity, tool, and TA support across other health areas
	AIDSFREE - Jhpiego	Benefits from USAID Tulonge Afya support towards development of SBC materials. Radio media and experiential marketing support to promote the uptake of VMMC and early circumcision in AIDSFREE support regions
	SAUTI – Jhpiego	Targeted key and vulnerable population SBC messages to promote condom use and testing services
	Kizazi Kypia – Pact	Participates in campaign development and uses *Furaha Yangu* and Adult Platform materials in reaching young and vulnerable populations, particularly pregnant women and caregivers.
	Community Health and Social Welfare Systems Strengthening	Participates in campaign development, launch, and implementation to reach more women in newborn and maternal health programs
	USAID Boresha Habari – Internews	Partner on media trainings and media engagement around proper reporting on key health thematic areas and desired behavior change needs
	VectorWorks/ VectorLink	Benefits from USAID Tulonge Afya's SBC materials to promote ITNs during distribution and on use
Subgrantee	T-MARC	Works on campaign development and adaptation at subnational levels and community engagement through civil society organizations (CSOs)
	Khangarue Media	Manages the creative component of Adult Platform SBC branding and materials production.
	Tanzania Communication and Development Center	Works on campaign development and adaptation at subnational levels and community engagement through CSOs; supports targeted Malaria activities
Other Partners	Marie Stopes, UMATI, TAMA, Pathfinder, PSI, DSW, DKT, CHAI, AMREF, UNCEF, UNAIDS, ILO, etc	Participates in campaign materials review meetings and receives artworks for reprint and utilization during campaign roll out and for their respective projects

Phasing and Sequencing

The Adult Strategy and related Platform are being implemented using a phased approach that is mindful of not overwhelming audience members with too much at one time. Under each SBC Package, specific behavioral priorities are determined in coordination with USAID, the GOT, and implementing partners to align with service delivery needs. Behaviors are promoted using the most appropriate channels to ensure targeted reach and cost-effectiveness. Promotion and engagement with audiences around some behaviors have heavier emphasis than others based on GOT and USAID priorities, epidemiological need, and their potential to impact multiple health outcomes.

Development of the pregnancy and childbirth package began in USAID Tulonge Afya Y1. This included consultations with the MOHCDGEC, key implementing partners, and stakeholders to secure consensus around a minimum package of materials and activities to be developed for the initial roll-out of the package, which took place early in Y2. This initial package is being expanded upon in Y3, with new materials and messages being phased in at appropriate times, as guided by audience feedback and project monitoring data. Rolling out materials and activities in stages has the dual advantage of: 1) reducing the risk of bombarding audiences with too many messages at once, allowing them time to adopt new behaviours without being overwhelmed by competing calls to action, 2) enabling the project to apply learning from the design and roll-out of initial materials to development of subsequent materials. A similar process is being taken for the Caregiving of <5 Children package, which began rolling out in FY20 Q2.

Each roll out has included implementing and local partner orientations, service provider orientations, and a phased program of mass media activities linked closely with community-level engagement. These minimum packages will continue to be refined and expanded on over the course of the Project.

The *Furaha Yangu* campaign was continued through the early part of FY19. After the initial phase of the campaign, emphasis has moved to more targeted approaches, aligned with service delivery goals and objectives for HIV priorities. This includes limited strategic use of mass media and greater saturation of community-based SBC activities, focused on reaching and engaging high-risk audiences and PLHIV. Moving into FY20, we have continued to refine our targeting strategies to ensure activities are appropriately aligned with GOT and USAID priorities in terms of target populations, behavioural priorities (e.g. inclusion of TLD transition, cervical cancer screening), and geographies. It will then be linked with NAWEZA, either as a sub brand or through tag lines, as new content is developed and as it becomes much more targeted in its approach at the community level.

Monitoring and Evaluation

To monitor implementation of this strategy, several activity indicators are collected through standardized activity report forms and analyzed on a regular basis. These indicators are monitored on a quarterly basis for the purposes of process evaluation and quality improvement. Activity indicators are outlined in below.

Indicator	Disaggregation	Data Source	Reporting frequency
Mass media activities			
Number of radio spots flighted	Theme, district	Agency reports	Quarterly
Number of community radio shows	Theme, district	Activity Reports	Quarterly
Mid-media activities			
Number of mid-media events organized	Theme, format, district	Activity reports	End of event
Number of participants in mid-media events	Theme, format, district	Activity reports	End of event
Health Care Workers			
Number of providers participating in client centered care trainings	District	Activity reports	Quarterly
Number of printed provider tools disseminated	District	Dissemination reports	Quarterly
Number of client takeaway materials distributed	Theme, district	Dissemination reports	Quarterly
Community Dialog Activities			
Number of community dialog sessions organized	Theme, district	Activity reports	End of event
Number of participants in community dialog sessions	Theme, district, age category	Activity reports	End of event
Community Based Organization (CBO)			
Number of CBOs participating in project activities	District	Activity reports	Quarterly
Regional and District Planning Workshops			
Number of Regional and District workshops held	Region, District	Participant register; end of group contact reports	Quarterly

Number of District Action plans developed	District	Activity reports	End of event
Number of Community Action Plans developed	Community	Activity reports	End of event
Number of supervision visits completed	District	Supervision reports	Quarterly

Additionally, programmatic targets for indicators tied to the project's behavioral and communication objectives and campaign exposure have been established and are monitored on a routine basis through quarterly omnibus and annual sentinel surveys (see further detail in the project's Activity Monitoring and Evaluation Plan). This enables evidence-based process improvements for the program.

To complement process evaluation activities, USAID Tulonge Afya will also use household surveys to compare levels of campaign exposure and subsequent improvements in behavioral determinants and health outcomes for each of the five health areas at two-time points to evaluate the effectiveness of the project. The team will model and test the program's theoretical framework using path analysis from the baseline data to inform what hypotheses are supported by the data and where the program may need to pursue additional formative research or consult the literature or key informants and subject matter experts.

Annexes

Annex A: Audience Profiles

PROFILE: PREGNANCY & CHILDBIRTH
USAID Tulonge Afya

ARCHETYPE: Mwanaidi S., 21, mum-to-be, first pregnancy, cohabitating

TARGET BEHAVIORS: ***Achieve more than 4 ANC contacts (ideally 8), utilize all essential prenatal services, begin thinking about PPFP, deliver at a facility, and attend post-natal clinics.***

Mwanaidi, 21, has just moved in with her partner, Seif, into a single-bed rental in Ukwega – a vibrant rural community in Kilolo, Iringa. She finished primary school when she was 15, worked with her mother for a bit. Now she manages her own *mitumba* stall during the a bi-weekly *gulio (market day).* She has been with Seif for 2 years and calls him *her husband* – he likes the label – but they are not officially married. Her family recognizes him as her partner. Her pregnancy was unplanned, though not unexpected as she is in a *stable* relationship.

Current Behaviors
(For ANC/pregnancy care): Mwanaidi has never been to a clinic for pregnancy-related care. She is not sure what to expect but may have heard women in her mother's social circle share their own experiences.

Demographics
- Age: 21 years old (representing married/partnered young women ages 20-24)
- Education: Primary school (44% of this cohort have some primary education)
- Marital: Co-habitating
- Residence: Rural with her baby's father
- Work: Owns/manages a market stall

Barriers & Facilitators

Individual-level barriers • Can't afford to miss a day of work • May have heard negative things about the clinic • Insufficiently informed about pregnancy risks	**Individual-level facilitators** • Wants to take care of her baby (nurturing) • Wants to give her baby a good start in life
Interpersonal-level barriers • Family/partners are insufficiently informed about pregnancy risks • Family/partners too busy to support all her visits	**Interpersonal-level facilitators** • Seif is *proud* to be a father, enhances his status • Family more willing to support since they *approve* of her living arrangements (i.e. with partner)
Community-level barriers	**Community-level facilitators**

• Norms: Mum never went and she turned out fine; who needs 8 visits – isn't that excessive? • Clinics are for when she's sick	• Greater community awareness around need for ANC
Social and Structural-level barriers • Clinic is too far	**Social and Structural-level facilitators** • Engaged CHWs; more likely to get personalized attention in her community

Psychographics

- *Likes to* talk to her friends about her life goals
- *Wants* stability for herself and her child
- *Thinks* Seif should step up and offer/do more
- *Believes* her partner has a duty to take care of her and her baby

Media Habits

- Television: Doesn't own one, sometimes catches a *Bongo Movie* from *Kibanda* near her stall
- Radio: Listens absent-mindedly in the evenings when she's preparing food/relaxing
- Mobile: Owns a feature phone and uses basic SMS services regularly

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PROFILE: PREGNANCY & CHILDBIRTH
USAID Tulonge Afya

ARCHETYPE: Grace R., 18, mum-to-be, first pregnancy, single

TARGET BEHAVIORS: ***Achieve more than 4 ANC contacts (ideally 8), utilize all essential prenatal services, begin thinking about PPFP, deliver at a facility, and attend post-natal clinics.***

Grace, 18, lives with her aunt in Kihonda – a 'varsity suburb' – in Morogoro. She was in a relationship with an older man and became pregnant in her third year of secondary school. She dropped out to have her child and has been at home since then. She has no contact and receives no support from her ex-partner. Grace dreams of a prosperous future for herself and thinks fashion retailing/opening a boutique might get her there. Does not know how to make that happen.

Current Behaviors
(For ANC/pregnancy care): Grace has never been to a clinic for pregnancy-related care and doesn't know what to expect. Her family is unhappy about her getting pregnant in school, so is not overtly supportive.

Demographics
- Age: 18 years old
- Education: 3 years of secondary school (37% of this cohort have some secondary education)
- Marital: Single
- Residence: Urban with extended family
- Work: Does not work, gets a small allowance working in her aunt's tuck shop

Barriers & Facilitators

Individual-level barriers • Clinics are for 'Mums'; may not see herself as one • Does not have money to cover transport to clinic	**Individual-level facilitators** • Above-average education, which increases her likelihood of her seeking service • *Safety*: may view safe delivery as a way to safeguard her own dreams
Interpersonal-level barriers • Family unapproving, so unwilling to explicitly support clinic visits	**Interpersonal-level facilitators** • *Nurturing*: expectation that she proves herself capable as a mum
Community-level barriers • Norms: might be judged for being a 'teen mum-to-be' • Minimal social support (little contact with school friends, not plugged into 'Mum' network)	**Community-level facilitators** • NA
Social and Structural-level barriers • May be turned away if unaccompanied by a partner	**Social and Structural-level facilitators** • Good government hospitals close by; does not need to go too far for care

Psychographics

- *Likes to* watch television and reality shows
- *Wants* to open up her own boutique
- *Thinks* she can achieve her dream.
- *Believes* she's destined for greater things than her current situation

Media Habits

- Television: Watches TV most evenings with family – movies, music, some lifestyle shows
- Radio: Rarely listens to radio – never deliberately
- Mobile: Owns an inexpensive smartphone, has access to WhatsApp and Instagram

PROFILE: PREGNANCY & CHILDBIRTH
USAID Tulonge Afya

ARCHETYPE: Aziza M., 32, mum-to-be, fourth pregnancy, married

TARGET BEHAVIORS: ***Achieve more than 4 ANC contacts (ideally 8), utilize all essential prenatal services, begin thinking about PPFP, deliver at a facility, and attend post-natal clinics.***

Aziza, 32, has been picking up casual work at a factory in Ngaramtoni, Arusha for the past 6 years. Her day starts early and ends late. She works hard and wants a better life for herself and her family. Her husband, Jonathan, drives a minibus (daladala). They have been married for 12 years. They don't have a lot but want the best for their three older children, and scrap and save so they can send them to good school. They had always wanted a much smaller family than they grew up in – but Jonathan wants a son. She hopes the fourth time is the charm and would rather this be her last pregnancy.

Current Behaviors
(For ANC/pregnancy care): Aziza has had progressively better experiences with pregnancy care. In her first pregnancy she nearly lost her child to complications from malaria. In her second and third, she went as often as her job allowed and it went well, without complications. For her fourth, she enrolled at ANC during her second trimester, but has missed a few contacts since.

Demographics
- Age: 32 years old
- Education: Primary
- Marital: Married
- Residence: Peri-urban with her husband and kids
- Work: Casual, low-paying

Barriers & Facilitators

Individual-level barriers • Cost: time, opportunity (misses the chance to work)	**Individual-level facilitators** • Positive prior ANC experience (increases the likelihood of clinic visits in third pregnancy)
Interpersonal-level barriers • NA	**Interpersonal-level facilitators** • Motivated partner (who *hopes* this pregnancy is a boy – enhances his status) • Peer pressure (if other Mums do it, so should I)
Community-level barriers • Norms: might be perceived as soft (why go to 8 ANCs after 2 kids?)	**Community-level facilitators** • Part of a network of mums/supportive friends who *empathize* with her • *Expectations*: that she'll 'do what is right' for baby
Social and Structural-level barriers • May worry about unreliable/unfriendly providers	**Social and Structural-level facilitators** • Government clinics are close by

	• Frequent visits by close friends with local CHW

Psychographics

- *Likes to* chat with work friends/other mums about family
- *Wants* financial security for her family
- *Thinks* she should be supportive of her husband's 'vision'
- *Believes* her husband has final say on all household decisions

Media Habits

- Television: Owns a set, but never has time to relax in front of the television
- Radio: Listens to talk radio at her job, but rarely at home
- Mobile: Owns a feature phone, rarely texts, often buys an in-network day-bundle (inexpensive talk time)

PROFILE: PREGNANCY & CHILDBIRTH
USAID Tulonge Afya

ARCHETYPE: Songa W., 25, dad-to-be, first time, single

TARGET BEHAVIORS: ***Support partner to achieve more than 4 ANC visits (ideally 8 contacts), utilize all essential prenatal services, talk to their partner about PPFP, and support their partner to deliver at a facility and attend post-natal clinics.***

Songa, 25, is an easy-going football fanatic who lives and breathes United. He has had an on-again, off-again relationship with Julie since their final year in high-school. He lives alone in a one-bedroom flat in Nyamagana, Mwanza and works as a clerk. He has always wanted a child *before* he was married to prove he's a 'proper lad', like all the men in his family. Pregnancy wasn't deliberate. Wants Julie to have the child but is non-committal to a long-term partnership.

Current Behaviors
(For ANC/pregnancy care): Songa has never supported a partner through pregnancy and knows nothing about ANC. He feels his role is to *secure* Julie's pregnancy, but doesn't see joint clinic attendance as part of it.

Demographics
- Age: 25 years old
- Education: Secondary (completed A 'levels)
- Marital: Single
- Residence: Urban, on his own
- Work: Clerk

Barriers & Facilitators

Individual-level barriers • Time & opportunity cost • May be uneasy around in-clinic HIV testing (doesn't want to know)	**Individual-level facilitators** • *Ego:* Wants to show he is 'dad-material'
Interpersonal-level barriers • Not close with Julie's family and this limits his involvement in her pregnancy • *Peer influence:* friends might question his 'manliness' if he shows up for every clinic visit	**Interpersonal-level facilitators** • *Status:* having a child enhances his masculinity • *Peer influence:* good dads *care* for their offspring
Community-level barriers • Norms: clinics are for women	**Community-level facilitators** • Norms: men are expected to *provide* for pregnant partners (transport, clinic costs, etc.)
Social and Structural-level barriers • NA	**Social and Structural-level facilitators** • Lives near a 'good' clinic / facility • Policies encouraging partner presence at clinic

Psychographics

- *Likes to* watch soccer with friends
- *Wants* his downtime/independence
- *Thinks* he can take care of baby without being in mum's life
- *Believes* he would make a good father

Media Habits

- Television: Owns a set – watches daily, often at a pub with friends; mostly sports
- Radio: Does not own a set; rarely listens
- Mobile: Owns a smartphone, has access to WhatsApp and Instagram

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PROFILE: PREGNANCY & CHILDBIRTH
USAID Tulonge Afya

ARCHETYPE: Bariki Y., 32, dad-to-be, fourth time, married

TARGET BEHAVIORS: ***Support partner to achieve more than 4 ANC visits (ideally 8 contacts), utilize all essential prenatal services, talk to their partner about PPFP, and support their partner to deliver at a facility and attend post-natal clinics.***

Bariki, 32, has been married to Zuhura for 7 years. They live in a small family home in Mombo, Tanga. They were introduced through a mutual family friend and have been together since. She is a homemaker, he grows fruit for a living. To supplement his income, Bariki works as a casual labourer in nearby Sisal plantations during harvest season. Work ebbs and flows, and with it, their earnings. They have 3 kids: 2 older boys and a four-year old girl.

Current Behaviors
(For ANC contacts/pregnancy care): Bariki has some experience with ANC, having supported Zuhura through her first pregnancy. He never went to the clinic though – his sisters took her. He expects them to support her this time too.

Demographics
- Age: 32
- Education: Primary
- Marital: Married
- Residence: Rural with his wife and child
- Work: Farmer, casual laborer

Barriers & Facilitators

Individual-level barriers • Time and cost	**Individual-level facilitators** • *Experience:* knows what to expect
Interpersonal-level barriers • *Peer influence:* friends might question his 'manliness' if he shows up for every clinic visit	**Interpersonal-level facilitators** • *Status:* having a child enhances his masculinity • *Affection:* invested in wife's health/well-being
Community-level barriers • *Norms:* Clinics are for emergencies • *Norms:* Clinics are for women	**Community-level facilitators** • Norms: men are expected to *provide* for pregnant partners (transport, clinic costs etc.)
Social and Structural-level barriers • Clinics are too far	**Social and Structural-level facilitators** • Policies encouraging partner presence at clinic

Psychographics
- *Likes to* spend time in his farm – his own personal space
- *Wants* to keep his family safe/secure
- *Thinks* his wife should stay on top of 'clinic stuff'

- *Believes* his job is done the minute he gets her a *bodaboda*

Media Habits

- Television: Does not own a set, almost never watches TV
- Radio: Listens frequently, has an old set he takes with him to his farm
- Mobile: Owns a basic feature phone, texts occasionally (basic SMS), rarely calls

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PROFILE: CAREGIVING
USAID Tulonge Afya

ARCHETYPE: Faraja K., 25, mum to Imani, 3.5 months.

TARGET BEHAVIORS: ***Use MCM to avoid pregnancy for at least 24 months postpartum, EBF for 6 months, receive care at first sign baby is ill, get baby vaccinated timely, and use ITNS to prevent malaria.***

When Faraja, 25, had Imani, she told herself she would do anything for her baby. She lives with her husband, Peter, in Manyoni, Singida, next door to her in-laws. They eke out a living selling sunflower seeds to a local oil press. Peter is quiet, shy, frustrated. They don't have much. She loves him, but when he drinks, he is mean and can sometimes be verbally abuse. Necessities are a struggle. Health is not a priority. The closest clinic is 20 km away - rarely an option for them. If Imani has a fever, mum-in-law, with whom Faraja is close, tells her not to worry, and offers traditional remedies. Imani is Faraja's only child, and she doesn't always trust she knows what's best for her.

Current Behaviors
(For Caregiving): Faraja breastfeeds Imani, though she doesn't *feel* she's making enough milk. She last took Imani to the clinic two months ago for vaccinations but hasn't been back since. She's not on contraception because she and Peter worry *she* will become infertile as they both want at least four more children.

Demographics
- Age: 25
- Education: Primary (50 percent of this cohort have completed primary school)
- Marital: Married
- Residence: Rural with husband and in-laws
- Work: Grows sunflower, subsistence farmer

Barriers & Facilitators

Individual-level barriers • Doesn't trust her *instincts* • *Knowledge:* doesn't know signs of infant illness (e.g. pneumonia)	**Individual-level facilitators** • *Nurturing:* wants the best for her baby
Interpersonal-level barriers • *Shared fear* of *infertility* (prevents contraception use) • *Control:* limited, dominant partner	**Interpersonal-level facilitators** • *Supportive* mother in law • *Peers:* if they seek care, so should I
Community-level barriers • *Norms:* belief *kids just go through these things*: Prevents care seeking if Imani runs a temperature • *Norms:* tendency to self-diagnose and self-medicate	**Community-level facilitators** • *Security:* belief in looking after child today so she can look after you tomorrow • *Knowledge* that nets are available for free*

• *Norms:* belief malaria is not serious	*Through community programs. May have to wait
Social and Structural-level barriers • *Distance & cost* to clinic	**Social and Structural-level facilitators** • *Policies* supporting post-natal contact and care

Psychographics

- *Likes to* share her aspirations for Imani
- *Wants* more than just survival for her child
- *Thinks* her husband needs to be more involved in childcare
- *Believes* that in-laws are allies in safeguarding her child's future

Media Habits

- Television: Doesn't own one – not part of her daily life
- Radio: Her husband has one; listens sometimes when they're out in the farm together
- Mobile: Does not own a phone; uses her husband's or sister-in-law's for *important* things

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PROFILE: CAREGIVING
USAID Tulonge Afya

ARCHETYPE: Salha N., 28, married, mum to 5.

TARGET BEHAVIORS: ***Use modern contraception as appropriate to support desired fertility, receive care at first sign the child is ill or has a fever, get the child vaccinated timely, and use ITNs to prevent malaria.***

Salha, 28, works hard to take care of her large family with husband, Dotto. They were married young, and have lived their entire life in Bunzilasoga, Sengerema. They're both cotton farmers like their parents before them, though these days they don't have much to show for it. Her youngest is 3 years old and has two older brothers and two sisters. She feels like she is at a point where she has had enough, though her husband is not supportive because in her culture children are a sign of wealth/foresight (as they're expected to look after you when you're older).

Current Behaviors
(For Caregiving): Salha has had 5 successful pregnancies over a decade and does not want more children. She struggles to take care of them (nutrition, healthcare, nets for all), but Dotto is not supportive of modern contraception.

Demographics
- Age: 28
- Education: Some primary
- Marital: Married
- Residence: Rural with partner and 5 children
- Work: Farmer

Barriers & Facilitators[1]

Individual-level barriers • *Afraid* that MCM might hurt her fertility, take away her 'womanhood' • *'Clinics are for new mums'* – less likely to seek care over ***little things*** like a fever	**Individual-level facilitators** • *Nurturing:* wants the best for all her *current* children, knows she can't *afford* another child
Interpersonal-level barriers • *Unsupportive partner*: mistrusts modern contraception, believes kids are proof of virility/ manhood & an 'investment'	**Interpersonal-level facilitators** • NA
Community-level barriers • *Norms:* perception MCM is for promiscuous people/sex workers. • *Belief* that large families are good • *Norms:* tendency to self-diagnose and self-medicate (for Malaria, childhood diseases)	**Community-level facilitators** • *Shifting norms* around number of children (as caregivers become aware of the costs they seek smaller families) • *Shifting perceptions* around Malaria treatment (perceived more positively)
Social and Structural-level barriers • *Distance* to facility	**Social and Structural-level facilitators**

• *Inconsistent* MCM availability at facility • *Providers' personal values* might reduce likelihood of suggesting certain methods	• *Policies* driving maternal care uptake (zero-cost care for under 5s)

Psychographics

- *Likes* to chat/gossip with the other mums.
- *Wants* to focus on her *current* children
- *Thinks* contraception might hurt her 'womanhood' (fertility fears)
- *Believes* her husband would never support contraception use

Media Habits

- Television: None: Never watches TV
- Radio: Household/partner has a portable set; listens when he's home
- Mobile: None – shares feature phone with partner; limited literacy, so calls mostly

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PROFILE: CAREGIVING
USAID Tulonge Afya

ARCHETYPE: Farida M., 31, cares for Nurhan, 2 years.

TARGET BEHAVIORS: ***Use modern contraception as appropriate to support desired fertility, receive care at first sign the child is ill or has a fever, get the child vaccinated timely, and use ITNs to prevent malaria.***

Farida, 31, found herself thrust into the role of caregiver when her younger sister, Nasra passed away during Nurhan's delivery. She lives with her husband, Omari, in Mwakibete – a sprawling neighbourhood on the outskirts of Mbeya. She has two boys in a local school (ages 10 and 7). Had always thought she was done. She owns a tailoring shop in Uyui, and he owns/manages a small garage in the city centre. They own their home and a car.

Current Behaviors
(For Caregiving): Farida knows the value of staying on top of baby's health. Nurhan is currently up on all her vaccinations and has an active clinic card. Farida had her on formula after her Mum left and is now firmly on solid food – whatever the family eats.

Demographics
- Age: 31
- Education: Tertiary (some college)
- Marital: Married
- Residence: Urban with husband, 3 kids and *dada**
- Work: Business owner

**house help.*

Barriers & Facilitators[1]

Individual-level barriers • Time & opportunity cost: can't always stay on top of Nurhan's needs, delegates to *dada* • Doesn't take Malaria seriously	**Individual-level facilitators** • *Nurturing:* wants the best for her niece • *Security:* has means to provide for Nurhan
Interpersonal-level barriers • *Power:* husband not full onboard with new child. Minimally engaged	**Interpersonal-level facilitators** • *Recognition:* need to present as a caring aunt
Community-level barriers • *Norms:* tendency to self-diagnose and self-medicate	**Community-level facilitators** • *Supportive* neighbors. Plugged to local network of Mums
Social and Structural-level barriers • *Long wait times* at clinics • *Unavailability* of essential medication (ACT, oral rehydration solution)	**Social and Structural-level facilitators** • *Location:* urban, close to decent hospitals

Psychographics

- *Likes to* talk about herself, her business, her goals
- *Wants* success for herself and her children
- *Thinks* hard work and perseverance will 'get her there'
- *Believes* she has a duty of care to family

Media Habits

- Television: Owns multiple sets, watches daily; mostly entertainment, gossip and local news
- Radio: Owns a set, but rarely listens to radio deliberately; catches the odd drivetime show
- Mobile: Owns a mid-end smartphone – WhatsApps and Instagrams extensively; watches Millard Ayo on YouTube

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PROFILE: CAREGIVING
USAID Tulonge Afya

ARCHETYPE: Mariam H., 40, grandmother to Emmanuel, 4.

TARGET BEHAVIORS: ***Use modern contraception as appropriate to support desired fertility, exclusively breastfeed for 6 months, receive care at first sign baby is ill and fever, and use ITNS to prevent malaria.***

Mariam, 40, has had her fair share of tragedy. She has lived through loss, having outlived her partner, killed in floods at their homestead in Kilosa, and her two children – Daudi, who drifted off to Dar and faded, and Neema, who she lost to AIDS. Her only solace is her grandson, Emmanuel, who she dotes on. She grows and trades rice to support herself. Has little time for anything else. They aren't wealthy, but she keeps the family home pristine.

Current Behaviors
(For Caregiving): Mariam understands the value of nets and ensures Emmanuel uses one when she sleeps. She finds them uncomfortable, however, so she personally doesn't use one. Malaria and dysentery worry her during Kilosa's drenched winters. Otherwise she never thinks of it.

Demographics
- Age: 40
- Education: Primary (56 percent of this cohort have completed primary school)
- Marital: Widow
- Residence: Rural with grandson
- Work: Rice farmer, trader

Barriers & Facilitators

Individual-level barriers • *Belief* that nets are not for her	**Individual-level facilitators** • *Nurturing:* wants the best for her grandchild
Interpersonal-level barriers • *Limited* support structures around her to help manage Emmanuel's care	**Interpersonal-level facilitators** • NA
Community-level barriers • *Norms:* tendency to self-diagnose and self-medicate • *Norms:* belief *kids just go thru these things*. Prevents care seeking	**Community-level facilitators** • *Security:* belief in looking after child today so she can look after you tomorrow • *Knowledge* that nets are available for free
Social and Structural-level barriers • *Distance & cost* to clinic	**Social and Structural-level facilitators** • NA

Psychographics
- *Likes to* brag about how hard she works
- *Wants* her grandson to succeed

- *Thinks* her grandson is special. Somehow.
- *Believes* kids these days are ‘soft.’ Need to toughen up.

Media Habits[3]

- Television: Does not own a set; almost never watches TV
- Radio: Frequent listener, loves music and talk shows (30 per cent of this cohort tune in daily)
- Mobile: Owns a basic feature phone, texts often (basic SMS), rarely calls

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PROFILE: FURAHA YANGU
USAID Tulonge Afya

ARCHETYPE: Amani K., 18, casual, at risk, status unknown.

TARGET BEHAVIOR: ***Go for HIV testing and counselling if at risk and receive results. If positive enroll in care and initiate ART.***

Amani, 18, had been out with friends in Chigongwe, Dodoma when they saw a white tent at Arafa. On a whim, they decided to get tested. He walked in, laughed with all his friends at how easy it was. Walked out without taking his results. He drives a *bodaboda*, which his uncle bought for him after he dropped out of school. He has a regular partner – Angela – with whom he never uses a condom. He has had sex on a few occasions with his female clients in exchange for free rides.

Current Behaviors
Amani has been tested, but he doesn't believe HIV is for 'people like him.' He trusts his girlfriend. Believes he is safe.

Demographics
- Age: 18 years old
- Education: Some secondary
- Marital: Casual
- Residence: Peri-urban, in a one-bedroom flat with his brother and cousin
- Work: Bodaboda driver

Barriers & Facilitators[1]

Individual-level barriers • *Perceived loss of control if positive*: over life, health, wellbeing	**Individual-level facilitators** • *Clarity:* Worries. Testing offers peace of mind • *Ambition:* wants to see through his dreams – would rather not let HIV (+/-) derail him.
Interpersonal-level barriers • *Stigma:* afraid if positive, friends and family will ostracize him, and that he may lose his relationship. Doesn't want his life to change.	**Interpersonal-level facilitators** • Personalized care from local CHW (if/ when he chooses to re-test) • *Peers:* encouraging, willing to test with him
Community-level barriers • *Stigma:* fears community will judge him for being reckless/promiscuous if he seeks testing services	**Community-level facilitators** • *Norms:* community supportive of testing, seen as taking charge of one's life
Social and Structural-level barriers • *Untrusted/unreliable* health workers. Feels disconnected from the health system.	**Social and Structural-level facilitators** • *Policies* supporting test and treat campaigns • *Zero-cost* counselling and ARVs/ART if positive

Psychographics[2]

- *Likes* soccer, hanging out with friends
- *Wants* to be loved and accepted
- *Thinks* he has life all figured out
- *Believes* whatever he sets his mind to, he can make happen

Media Habits[3]

- Television: Shared set, watches soccer and Naija music videos in the evening
- Radio: Listens to FM radio mostly through his phone
- Mobile: Low-cost feature phone, SMSs often, rarely calls

PROFILE: FURAHA YANGU
USAID Tulonge Afya

ARCHETYPE: Shukuru J., 35, HIV positive, married

TARGET BEHAVIOR: ***Adhere to ART as prescribed and go for routine viral load monitoring.***

Shukuru, 35, is a man-about-town. Sharp-witted and affable, he's done every kind of business imaginable – legal and on the murkier side of things. He is a long-distance trucker who ferries lumber between Morogoro and Malawi. His job keeps him on the road, away from his family. He's married to Arafa. They have a 5-year-old. Seven years ago, he found out he was HIV+. Sharing his status with his wife was the most difficult thing he had ever done because he's had multiple concurrent partners in the past. Arafa is HIV positive too, and they are both presently on ARV therapy, but with a growing business that requires a lot of travel, he struggles to follow his medication schedule and sometimes misses a dose. On a few occasions when he has run out, he takes his wife's ARVs, putting her health at risk too. Their daughter is HIV negative.

Current Behaviors
(For Well Being): Shukuru and is partner have been on ART for several years. They know what signs to look out for, but struggle to stay on treatment schedule.

Demographics
- Age: 35 years old
- Education: Primary school
- Marital: Married
- Residence: Rural with partner, one child
- Work: Trucker, business owner

Barriers & Facilitators

Individual-level barriers • *Internal stigma:* doesn't want to be seen seeking care • *Time/opportunity cost:* gives up scheduled treatment if it affects his ability to earn	**Individual-level facilitators** • *Informed* about his status, treatment options • *Protective* of his family. Wants to do right by his daughter
Interpersonal-level barriers • N/A	**Interpersonal-level facilitators** • *Supportive*, *empathetic*, HIV+ partner. Shared experience
Community-level barriers • *Stigma:* fears community will judge him for being reckless/promiscuous	**Community-level facilitators** • *PLHIV support structure:* part of a local support group
Social and Structural-level barriers • Stretched, distant, overburdened facilities in his area. Can't access all the services he needs sometimes.	**Social and Structural-level facilitators** • *Policies* supporting test and treat campaigns. • *Zero-cost* ARVs/ART

Psychographics

- *Likes* being out on the road – opportunity
- *Wants* to be a good father/provider
- *Thinks* his children are his legacy
- *Believes* family is everything.

Media Habits

- Television: Rarely watches TV, catches the odd match
- Radio: Listens regularly during the day (when he's waiting for passengers)
- Mobile: Low-cost smartphone, WhatsApps and texts regularly

PROFILE: FURAHA YANGU & CAREGIVING
USAID Tulonge Afya

ARCHETYPE: Hulda M., 25., cohabitating, HIV+, mother to Nyota, 6 months.

TARGET BEHAVIOR: ***Bring your infant to the health facility for HIV testing if mother is positive or status unknown. Linkage with Other Caregiving <5 Package Behaviors***

Hulda, 25, grew up in Igalula, Uyui in a large household. Growing up she wanted to be a teacher. A pregnancy and subsequent miscarriage in Form 3 cut short her dreams. She worked in the family bee farm for a while then left for Nzega, where she took whatever job came her way to support herself (cleaning, laundry). She's had a few partners, settled down with Haji two years ago. During a clinic visit early in her pregnancy she found out she was HIV+. Haji has not tested.

Current Behaviors
(For Pregnancy & HIV): Hulda knows her status, received PMTCT care during ANCs and is on ART. She breastfeeds Nyota normally. The baby looks healthy so Hulda thinks they're safe and has not had him tested. Her partner is also reluctant to have his son tested (and labelled).

Demographics
- Age: 25
- Education: Secondary
- Marital: Cohabitating
- Residence: primary home is rural, presently peri-urban
- Work: Casuals/does odd jobs

Barriers & Facilitators[1]

Individual-level barriers • *Knowledge:* inadequate awareness of early infant diagnosis (EID) services • *Belief* that baby looks healthy, so must be. No test needed.	**Individual-level facilitators** • *Nurturing:* caring, wants to keep Nyota healthy • *Respect:* may feel validated as 'mum' if she does *the right thing* i.e. seeks EID
Interpersonal-level barriers • *Partner*: unsupportive, doesn't want his son associated with 'sickness'	**Interpersonal-level facilitators** • *Peers & friendly CHW*: encourage her to look after herself and her baby
Community-level barriers • *Stigma:* thinks community & peers will judge her for being reckless, passing HIV to baby if +	**Community-level facilitators** • *Shifting norms:* more acceptable to talk about HIV testing in public • Local CHW/outreach network.
Social and Structural-level barriers • *Semi-rural locale,* limits access to facility • *Judgement:* because status is indicated in clinic card. Doesn't want to be 'labelled'.	**Social and Structural-level facilitators** • *Policies* supporting early infant diagnosis • *Zero-cost* ARVs/ART and child health care

Psychographics

- *Likes* to read. Harbors her dreams of teaching (still)
- *Wants* a large family (like she grew up in)
- *Thinks* this (partner, child, family) is it for now
- *Believes* in making the best of her circumstances

Media Habits

- Television: None -- watches sometimes at friends'/jobs.
- Radio: Regular listener; evenings mostly (or when home)
- Mobile: Basic feature phone – Texts mostly, some calls (to clients)

PROFILE: FURAHA YANGU & PREGNANCY AND CHILDBIRTH
USAID Tulonge Afya

ARCHETYPE: Assunta P., 23, third pregnancy, HIV+, married

TARGET BEHAVIOR: ***Go for HIV testing, attend PMTCT, and take ART regularly as prescribed, go for routine viral load monitoring, have baby tested for HIV during PNC (week 4 to 6), and other Pregnancy and Childbirth Package behaviors.***

Assunta, 23, has spent her whole life in Lengatei, Manyara. That's her world. She went to a local school till her parents pulled her out when she was in Standard 4 and married her off as wife number three to Lanyawa – then 55. They've been together for 8 years. He's kind, but authoritarian. His word is law in his *boma*. She defers to him. She feels her status among other co-wives is diminished because she has not given him a child. She has had two miscarriages, and a difficult third pregnancy. During her second pregnancy, she found out she was HIV+ at a local outreach clinic and began ART. She never told her partner and hides her medication. A young CHW sees her every few days because she works across a vast area but Assunta can't always get her ART refilled on time. She gets sick and worries she might lose this baby too.

Current Behaviors
(For Pregnancy & HIV): Limited experience with pregnancy care. Has been on ART on and off for 3 years. Nearest clinic is 17 km away – she rarely goes. Husband disapproves of her being away from the household for too long. Engaged via outreach clinics.

Demographics
- Age: 23
- Education: Some primary
- Marital: Married
- Residence: Rural, with husband and co-wives
- Work: Stay-at-home mum

Barriers & Facilitators[1]

Individual-level barriers • *Fear:* of being found out, of 'failing' as a mother • *What if her life changes?* Wants to safeguard her place in the household. An HIV+ status risks that.	**Individual-level facilitators** • *Nurturing:* wants to deliver safely
Interpersonal-level barriers • *No agency*: husband determines household decisions • *Unsupportive family*	**Interpersonal-level facilitators** • *Supportive* CHW who checks in with her when she can
Community-level barriers • *Limited community awareness* of benefits of ANC in HIV prevention	**Community-level facilitators** • PLHIV support group near her – but she's not sure she wants to be associated with 'those people'
Social and Structural-level barriers	**Social and Structural-level facilitators**

• Facility is *too far* • *Limited access* to reliable HIV counselling & ART refill opportunities	• *Supportive* ANC policies and care (when she can get to it) • *Policies* supporting test and treat campaigns • *Zero-cost* ARVs/ART

Psychographics[2]

- *Likes* to think of what might have been had she been allowed to finish school
- *Wants* to fit it – be part of the family
- *Thinks* she is not a good wife because she does not have a child
- *Believes* in protecting her husband from some truths (e.g. her HIV status)

Media Habits[3]

- Television: Does not own a set. No electricity.
- Radio: Listens infrequently - when her husband takes out his battery-operated portable
- Mobile: Has never owned a handset

PROFILE: FURAHA YANGU
USAID Tulonge Afya

ARCHETYPE: Romana J.,73, widower, cares for Edo, 9 who is HIV+

TARGET BEHAVIOR: ***Enroll in care, initiate and take ART regularly as prescribed and go for routine viral load monitoring.***

When Edo, 9, came into Romana's life, the 73-year-old had been retired for seven years. Her husband had passed on a year earlier, and Romana was whittling away time – joking she was 'on her way out.' She never had a child but was a favorite aunt of Edina, Edo's mother, who died of HIV-related pneumonia in 2012. For the past six years Romana has been solely responsible for Edo's wellbeing. Her elderly brothers try to be supportive, but they can't offer much. Her small pension pays the bills and tuition fees for Edo – and in her rural homestead in Kilolo, Iringa, they get by.

Current Behaviors
(For HIV): Extensive experience caring for HIV+ under 15. Knows Edo's ART regimen and tries to enforce it, but sometimes forgets. Jamila, her CHW, has asked neighbors to check in on them regularly.

Demographics
- Age: 73 years old
- Education: Secondary/vocational
- Marital: Widower
- Residence: Rural, with grandnephew
- Work: Retiree (former Agricultural Extension Officer)

Barriers & Facilitators[1]

Individual-level barriers • *Age:* hyper-active grandnephew knows status, but too young to understand how critical ART is • *Limited income:* affects ability to seek additional care for Edo if needed	**Individual-level facilitators** • *Nurturing:* wants to secure Edo's future • *Empowered:* relatively educated, knows the importance of sticking to ART
Interpersonal-level barriers • Her family, while supportive, lives too far and can't always facilitate/support clinic visits	**Interpersonal-level facilitators** • *Supportive* network of friends and neighbors (mostly elderly women like herself)
Community-level barriers • *Stigma:* fears for Edo's well-being and ability to make friends if he's labelled as 'that kid with HIV'	**Community-level facilitators** • *Shifting norms:* HIV testing more desirable/acceptable
Social and Structural-level barriers • *Rural locale,* limits access to facility • Does not *trust* local providers, feels they're underqualified	**Social and Structural-level facilitators** • *Policies* supporting test and treat campaigns • *Zero-cost* ARVs/ART

Psychographics[2]

- *Likes* to play with her grandnephew. Makes her feel young.
- *Wants* a secure future for Edo
- *Thinks* she would be a better caregiver for Edo if she had a larger income
- *Believes* she knows what is best for her grandnephew

Media Habits[3]

- Television: Does not own a set
- Radio: Regular listener of daytime radio; always on when she's home.
- Mobile: Basic feature phone. Calls, mostly with family & relatives. Rarely texts.

PROFILE: FURAHA YANGU
USAID Tulonge Afya

ARCHETYPE: Nuru B., 22, single mother of two, at risk.

TARGET BEHAVIOR: ***Go for HIV testing and counselling if at risk.***

Nuru, 22, has just moved from Nyamanyere, a rural hamlet in Nkasi to Sumbawanga Mjini to learn to be a hairdresser. Until two years ago, she went to a ward secondary school in her village but was not chosen for A 'levels. She's had an older partner for a while with whom she's had a child. He supports her sometimes. She also has a child with Jabiri – her high-school sweetheart who she says she loves. She's been looking for a way up – and had tried a couple of odd jobs, but in Nyamanyere, opportunities are limited. Her friend, Zahara, connected her to an *aunt* who runs a popular salon in Sumbawanga who agreed to host her and *has already told* her there are ways for her to bump up her earnings. Nuru is determined to do whatever it takes to make enough money to send back to her mother.

Current Behaviors
(For HIV): Nuru took a HIV test and was found negative in her last year of school. She tested with peers during a test & treat drive but does not see herself as 'at risk' because she only has two partners.

Demographics
- Age: 22
- Education: Secondary
- Marital: Single
- Residence: primary home is rural, just moved to town where she shares a room with Zahra.
- Work: Trainee hairdresser

Barriers & Facilitators[1]

Individual-level barriers • *Naivety:* uninformed, may not know she's at risk • Clinic visits cost money, which she does not have	**Individual-level facilitators** • Wants to safeguard *her future.* Knowing her status could help her plan.
Interpersonal-level barriers • N/A	**Interpersonal-level facilitators** • Supportive *peers* who are willing to test with her
Community-level barriers • *Stigma:* PLHIV still 'flagged', affects her willingness to test (fear of association) • *Judgement:* afraid testing could cause her to be perceived as promiscuous	**Community-level facilitators** • *Shifting norms:* more acceptable to talk about HIV testing in public. • Local CHW / outreach network.
Social and Structural-level barriers • Perceives the health system as *unsympathetic*	**Social and Structural-level facilitators** • *Policies* supporting test and treat campaigns • *Zero-cost* ARVs/ART

• *Provider's* personal values may affect their ability to offer her counselling without judgement	• *Good facilities* close to her

Psychographics

- *Likes* music and fashion.
- *Wants* a good life for herself and her family
- *Thinks* nothing can stop her
- *Believes* in doing whatever it takes to get what she wants

Media Habits

- Television: Does not own a set but watches daytime TV at work
- Radio: Listens to nighttime radio in shared residence (music, talk, lifestyle)
- Mobile: No phone, borrows Zahara's when she needs to call home

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PROFILE: FURAHA YANGU
USAID Tulonge Afya

ARCHETYPE: Mwasiti L., 25, HIV+, TB co-infected.

TARGET BEHAVIOR: ***Take ART regularly as prescribed, go for routine viral load monitoring, seek care from a qualified TB provider for a cough that persists for more than 2 weeks and adhere to the full course of TB treatment.***

Mwasiti, 25, works as a fish/food vendor in Nyamatongo, Sengerema. From a young age she has had to support her elderly mother. To make ends meet, she sometimes 'dates' her suppliers when she doesn't have cash to pay for a fresh catch. Two years ago, she found out she was HIV+ and has been on ART since then – though she doesn't always complete her treatment. A couple of weeks ago, she began feeling extremely tired, with night sweats and a persistent cough. She has booked an appointment at a clinic for tests but hasn't had time to follow through.

Current Behaviors
(For Tuberculosis): Mwasiti has no experience with Tuberculosis testing or care. She knows she is at greater risk because of her HIV status but has not had a check.

Demographics
- Age: 25
- Education: Some primary
- Marital: Single
- Residence: Rural
- Work: Fish vendor

Barriers & Facilitators

Individual-level barriers • TB threatens her *control:* Disempowers her, can't work, may wreck her transactional relationships	**Individual-level facilitators** • *Family values: May* seek care if she thinks TB could hurt future fertility
Interpersonal-level barriers • *Stigma:* judgement if she has / shows signs of TB • *Stigma:* fear of contagion might affect peer's willingness to be supportive	**Interpersonal-level facilitators** • *Personal relationship* with *CHW* (who supported her through HIV diagnosis) could drive decision to check for TB
Community-level barriers • *Perceptions* that TB means you're a 'terminal' HIV case	**Community-level facilitators** • *Shifting norms:* more acceptable to talk about HIV and TB testing
Social and Structural-level barriers • TB 'an anomaly' even within the health system • Limited practitioner expertise with extended TB care	**Social and Structural-level facilitators** • *Policies* supporting TB interventions • *Zero-cost* treatment for TB and HIV

Psychographics

- *Likes* hanging out with her peers (connection).
- *Wants* stability (someone to take care of her & her Mum)
- *Thinks* she is destined to have a family of her own someday
- *Believes* everything works out in the end

Media Habits

- Television: None, rarely watches.
- Radio: Listens when working
- Mobile: Owns a feature phone, mostly texts

PROFILE: TB STANDALONE MINI CAMPAIGN
USAID Tulonge Afya

ARCHETYPE: Kilomo K., HIV negative, at risk for TB.

TARGET BEHAVIOR: ***Seek care from a qualified TB provider for a cough that persists for more than 2 weeks.***

Kilomo, 30, works hard. His days are tough – life in Karama's diamond mines is not for the faint of heart. He spends up to 6 weeks at a time in a miner's camp, working long shifts in cramped tunnels. He doesn't like the camp – it is noisy and always crowded. He shares sleeping quarters with a few friends from back home. Lately, he often feels too tired to work and won't stop coughing. He thinks it might be a cold. Whenever he's made a bit of money, he travels back home to Rusohoko to see his wife and children.

Current Behaviors
(For Tuberculosis): Kilomo has no experience with Tuberculosis testing or care. He knows about TB from community mobilizers who come to camp to encourage HIV testing. He has never been tested. Has multiple partners (wife back home, camp wife).

Demographics
- Age: 30
- Education: Some primary
- Marital: Married
- Residence: Peri-Urban/Rural
- Work: Miner

Barriers & Facilitators[1]

Individual-level barriers • *Knowledge:* doesn't understand risk, uninformed • *Ego/Status:* does not want to be labelled as 'sick' or weak	**Individual-level facilitators** • *Economic cost: May feel* compelled to seek care if cough affects his ability to work
Interpersonal-level barriers • N/A	**Interpersonal-level facilitators** • *Peers:* supportive, want to protect themselves, pushing Kilomo to get checked
Community-level barriers • *Stigma:* fear of contagion might affect peer's willingness to be supportive • *Perceptions* that TB means you're also HIV+	**Community-level facilitators** • *Shifting norms:* more acceptable to talk about HIV and TB testing • *CHW / health workers* perceived as having 'the right information
Social and Structural-level barriers • TB 'an anomaly' even within the health system • Limited practitioner expertise with extended TB care	**Social and Structural-level facilitators** • *Policies* supporting TB interventions • *Zero-cost* treatment

Psychographics

- *Likes* his work underground (personal space)
- *Wants* the admiration and respect of his friends
- *Thinks* he's smarter than the average guy
- *Believes* he is a good husband/father and a good provider

Media Habits

- Television: Does not own a set but catches the odd match with friend when in camp
- Radio: Frequent listener, usually when working
- Mobile: Owns a feature phone, mostly texts

PROFILE: CROSSCUTTING
USAID Tulonge Afya

ARCHETYPE: Eliza R., 40, nurse (facility- based), married

TARGET BEHAVIOR(S): ***Deliver total care by pregnant women, clinical care for under 5s and their caregivers, HTC, and/or offer supportive care for those living with chronic illnesses such as HIV and TB.***

Eliza, 40, has been a nurse for 18 years. She has worked in multiple hospitals across Tanzania as a reproductive health/maternal health practitioner. She is a mother of 3. Her husband was recently appointed headmaster at Mkalama in Singida, so they uprooted the family from Manyara. When they arrived, she found a role at a nearby ward clinic as the only dedicated RCH nurse. Because of a dearth of clinical officers, she often steps to support all clinical services, including care for individuals living with chronic illnesses.

Current Behaviors
Extensive experience delivering RCH care for rural women across Tanzania. As a mother and practitioner, she understands their fears, anxieties and frustrations first-hand. Experience supporting HIV test and treat and TB clinical care for both early and end-stage patients.

Demographics
- Age: 40
- Education: College
- Marital: Married
- Residence: Rural with her husband and 3 children
- Work: Nurse (RCH)

Barriers & Facilitators

Individual-level barriers • *Bias:* against mums who don't meet her standards (single, too young etc.) • *Skillset:* Limited expertise with extended care for TB patients	**Individual-level facilitators** • *Status:* wants recognition for *bettering* the lives of pregnant women in this rural patch • *Nurturing:* feels compelled to look after others, especially young mothers
Interpersonal-level barriers • *Social distance* between her and her patients (skews power dynamic, perceived as 'unfeeling', might make it difficult for them to engage her)	**Interpersonal-level facilitators** • Knowledge that she is part of the local community and has duty of care
Community-level barriers • *Perception:* Providers are rude/uncaring. Hurts uptake • *Belief:* That traditional birth attendants are 'better'	**Community-level facilitators** • *Belief*: That clinicians know best. She's a trusted source of info
Social and Structural-level barriers	**Social and Structural-level facilitators**

• Understaffed / under resourced facility (leading to exhaustion, burnout, frustration)	• *Policies* encouraging / promoting maternal care • *Broadening access* to test and treat services

Psychographics

- *Likes to* take young mums under her wing
- *Wants* to protect mother & baby
- *Thinks* she has a duty of service to others but is often resource and time constrained to offer the type of service she believes her community deserves.
- *Believes* family always comes first

Media Habits

- Television: Own one, watches local news and local soapies
- Radio: Listens to local/national radio during her shift
- Mobile: Owns a mid-range smartphone, uses WhatsApp & SMS extensively

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PROFILE: CROSSCUTTING
USAID Tulonge Afya

ARCHETYPE: Kabula J., 28, community health worker, married

TARGET BEHAVIOR(S): ***Support uptake of total care by pregnant women, clinical care for under 5s and their caregivers, HTC, and/or offer supportive care for those living with chronic illnesses such as HIV and TB.***

Kabula, 28, fell into health care by accident. After her o'levels in Liwale she headed out to Nachingwea to help out at her family's cashew grove. She met Abuu in her late teens, got married, had twins girls – now 9. For most of her early 20s she was a stay-at-home Mum. A friend linked her to a local network where she mobilized for entrepreneurship groups. 4 years ago, she enrolled on a whim in a govt-sponsored workshop for health advocates. She's become one of the most effective CHWs in her ward. Folks sometimes forget she's not a nurse – a fact she is quick to own up to, though she sometimes does 'visual' diagnoses to get her more stubborn friends to go to the hospital.

Current Behaviors
Practiced health mobilizer with extensive community ties. *Trusted* link to local healthcare. Has supported new mums through pregnancy. Frequently mobilizes for HIV testing campaigns and can profile women at risk.

Demographics
- Age: 28
- Education: Secondary (23% of her cohort have a secondary education)
- Marital: Married
- Residence: Rural with her husband and twin girls
- Work: Community Health Worker (CHW)

Barriers & Facilitators

Individual-level barriers • *Skillset:* non-medical, limits ability to offer deep care • *Comp & benefits:* doesn't make much, needs side hustles	**Individual-level facilitators** • Able to connect, share info due to prior work as a community mobilizer
Interpersonal-level barriers • *Unsupportive partner*: husband worries about her contact with PLHIV/TB patients	**Interpersonal-level facilitators** • Social proximity with her community (viewed as one of them, trusted, loved)
Community-level barriers • Unrealistic expectations that she can offer total clinical care (reduces follow-thru when clients realize she can't) • *Stigma:* against her patients, and by extension, her	**Community-level facilitators** • *Trusted* link to local healthcare, connected to a local facility
Social and Structural-level barriers	**Social and Structural-level facilitators**

• Strained healthcare system. Can't always get her clients access to the clinical services they need.	• *Policies* driving maternal care uptake • Broadening *access* to test and treat services

Psychographics

- *Likes* "the connection" i.e. buzz from gaining a new client
- *Wants* a more secure income from her work
- *Thinks* with her skills, she can do better
- *Believes* her work (in health mobilization) is meaningful

Media Habits

- Television: None, rarely watches TV
- Radio: Listens to national during her downtime (at home, evenings, when making meals)
- Mobile: Owns a low-cost feature phone, texts occasionally, mostly receives calls from her clients

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