THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

iDARE FOR SOCIAL BEHAVIOR CHANGE ACTIVITIES TOOLKIT

Addressing Gender, Youth, and Social Inclusion Gaps to Improve Health Behaviors

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TABLE OF CONTENTS

ACKNOWLEDGEMENT 1

BACKGROUND 2

INTRODUCTION AND RATIONALE 3

PROCESS OF DEVELOPMENT 4

WHO IS THIS TOOL FOR? 5

WHY IS THIS TOOL IMPORTANT? 5

IDARE METHODOLOGY 5

HOW TO APPLY THE TOOLKIT 6

HOW THE TOOLKIT IS ORGANIZED 6

STEPS FOR INTEGRATING GYSI INTO SOCIAL AND BEHAVIOR CHANGE PROGRAMS 7

STEP 1: IDENTIFY 8

1.1 IDENTIFY THE GAP(S) IMPACTING AN INTENDED OUTCOME 8

1.2 DETERMINE THE PROBLEM AND MAGNITUDE 10

1.3 TEAM FORMATION AND FUNCTIONALITY 10

1.4 IDENTIFY GYSI ISSUES 12

1.5 DOCUMENT THE GYSI ISSUES 12

STEP 2: DESIGN 13

2.1 DEVELOP SOCIAL AND BEHAVIOR CHANGE ACTIVITIES TO TEST 13

STEP 3: APPLY AND ASSESS 14

3.1 IMPLEMENT THE CO-DESIGNED SOLUTIONS 14

3.2 MONITOR AND DOCUMENT CHANGES IN THE DESIRED HEALTH OUTCOME 14

3.3 CONDUCT LEARNING SESSIONS 14

STEP 4: RECORD 15

4.1 PACKAGE SOLUTIONS THAT WORK 15

5. STEP 5 EXPAND 17

5.1 IDENTIFY NEW AREAS, CONTEXTS, AND OR TEAMS TO SCALE UP IDARE EFFORTS 17

ANNEX A. IDARE TEAM ROSTER 18
ANNEX B. IDARE JOURNAL 20
ANNEX C. IDARE QUESTION GUIDE 25
ANNEX D. COACHING GUIDE 29
ANNEX E. GLOSSARY OF KEY TERMS 35
ANNEX F. PROBLEM TREE WORKSHEET 38
ANNEX G. VLS CHANGE PACKAGE 40
RATIONALE FOR CHANGE PACKAGE 41
EXPECTED USERS OF THE CHANGE PACKAGE 42

ACRONYMS

ARV	Anti-retroviral
ART	Anti-retroviral Therapy
FP	Family Planing
GBV	Gender-Based Violence
GYSI	Gender Youth and Social Inclusion
HC	Health Centre
HIV	Human Immunodeficiency Virus
iDARE	Identify, Design, Apply/Assess, Record, Expand
IP	Implementing Partner
ITNs	Insecticide Treated Nets
JCRC	Joint Clinical Research Center
MNCH	Maternal, Newborn and Child Health
PNC	Postnatal Care
RHITES-E	Regional Health Integration to Enhance Services in Eastern Uganda
SBC	Social and Behavior Change
SBCA	Social and Behavior Change Activity
SBCC	Social and Behavior Change Communication
SMART	Specific, Measurable, Attainable, Relevant, Time-bound
TASO	The AIDS Support Organization
TB	Tuberculosis
USAID	United States Agency for International Development
VLS	Viral Load Suppression
CCP	Johns Hopkins Center for Communication Programs
TMCG	The Medical Concierge Group
YAPS	Youth and Peer Supporters

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SECTION I

BACKGROUND

01 INTRODUCTION AND RATIONALE

Gender and youth-sensitive and inclusive programming is critical to the work of the United States Agency for International Development (USAID). Globally, the integration of gender into development has become a priority due to the tradition of designing, implementing, and monitoring programs without intentional consideration for gender differences in resources, knowledge, access, and care. This old type of design and rollout has led to gaps in outcomes across all sectors of development.

The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures, change over time, and often intersect with other factors such as race, class, age, and sexual orientation. But one thing does not vary: one's gender[A glossary of key terms, at the end of this toolkit, gives the definitions of sex, gender, social inclusion, as well as terms used in the toolkit.], sex, and other identity markers impact access to health services or, even more broadly, social programs and their outcomes. Going beyond being gender aware, it is also important to consider additional individual attributes that may impact access or exclude groups of people; for example, people with disabilities, people living with mental health illnesses, and children. It is not possible to realize developmental goals without promoting and attaining gender, youth, and social inclusion (GYSI) in programming. Social dynamics and cultural norms play a factor in the impact gender, sex, age, socio-economic status, religion, and a cadre of other identity markers have on health and overall developmental outcomes. See glossary (Annex E) for definitions of key terms used in this toolkit.

In the health development sector, evidence shows that individuals are increasingly aware of the importance of health-seeking behavior (Bird and Rieker, 2008), and a growing body of evidence demonstrates that incorporating approaches to address GYSI in programs can improve health outcomes. However, despite this evidence, GYSI continues to be inadequately addressed across global development initiatives (Rotech et al., 2017).

Implementation of the iDARE methodology in Uganda began in 2015 under the USAID ASSIST project, where the aim was to improve the quality of care by designing, monitoring, and evaluating programs with the aim of ensuring gender integration in the different programs. Integration of gender means identifying and addressing gender-related determinants to health). as an integral part of the design and implementation of the project's social and behavior change activities. Social inclusion refers to interventions that seek to ensure full participation of all community members in an activity or program. Therefore, exclusion may result from power and decision-making imbalances, access to resources, cultural norms and practices, roles and participation, and policies. Failure to address exclusion creates an imbalance in access and utilization of health services. These are significantly embedded in the cultural and social norms that determine the roles of boys and girls.

Under USAID's Operational Policy ADS 205, promoting gender equality and advancing the status of all women and girls around the world is a key priority. In 2012, USAID adopted several comprehensive and interlinked policies and strategies to reduce gender inequality and to enable girls and women to realize their rights, determine their life outcomes, influence decision-making, and become change agents in households, communities, and societies, including in first identifying the five domains in which gender barriers adversely impact developmental outcomes.

- **Laws, Policies, Regulations, and Institutional Practices that influence the context in which men and women act and make decisions:** Laws include formal statutory laws and informal and customary legal systems. Policies and regulations include formal and informal rules and procedures adopted by public institutions for making decisions and taking public action. Institutional practices can be formal or informal and include behaviors or norms related to human resources (hiring and firing), professional conduct (workplace harassment), and the like.

- **Cultural Norms and Beliefs:** Every society has cultural norms and beliefs (often expressed as gender stereotypes) about what the appropriate qualities, life goals, and aspirations are for males and females. Gender norms and beliefs are influenced by perceptions of gender identity and expression and often supported by and embedded in laws, policies, and institutional practices.

- **Gender Roles, Responsibilities, and Time Use:** The most fundamental division of labor within all societies is between productive (market) economic activity and reproductive (non-market) activity. This is the central social structure that characterizes male and female activities.

- **Access to and Control over Assets and Resources:** A key component of gender analysis is an examination of whether females and males own and/or have access to and the capacity to use productive resources – assets (land, housing); income; social benefits (social insurance, pensions); public services (health, water); and technology – and information necessary to be a fully active and productive participant in society.

- **Patterns of Power and Decision-making:** This domain of gender analysis examines the ability of women and men to decide, influence, and exercise control over material, human, intellectual, and financial resources in the family, community, and country. It also includes the capacity to vote and run for office at all levels of government.

To address gaps in the Ugandan context, the USAID Social and Behavior Change Activity (SBCA) set out to demonstrate the effectiveness of social and behavior change (SBC) interventions through the learning site approach. Since 2020, SBCA has supported regional implementing partners (IPs), including RHITES-E, TASO, and JCRC, as well as SBCA learning sites/districts and facilities to implement WI-HER's IDARE methodology to feed into SBCA Uganda's Experience Lab[3] to determine efficacy and document best practices. The iDARE methodology guides programs in identifying GYSI gaps and issues affecting health-seeking behavior as a predictor of health care utilization, integrating GYSI into the programming and learning cycle through locally led and co-created creative solutions to complex problems.

02 PROCESS OF DEVELOPMENT

This document was developed through partnerships and collaboration with IPs and the host district local government. A joint learning session was held in Tororo pilot district, which was attended by the regional IP, district health office, health facilities, and community influencers. Continuous reviews and input to the draft were made, with insights given on how to improve the structure and the content of the tool kit for the benefit of the intended users. Evidence from the implementation of iDARE was reviewed to inform the process. Insights collected through the joint onsite coaching in Kaberamaido, Kapchorwa, Kyegegwa, Bushenyi, and Kabale learning sites in partnership with TASO, JCRC, and RHITES-E were also used to inform the process.

iDARE has successfully demonstrated improvement in the health areas of HIV, tuberculosis (TB), and maternal, newborn, and child health (MNCH), including family planning, antenatal care (ANC), and immunization services. This process is ongoing, and the toolkit will be continually updated as more evidence comes to light.

What is this tool intended for?

This tool is intended to achieve three main objectives, namely to:

I. Provide stepwise guidance to users in the process of applying iDARE to close gender, youth, and social inclusion gaps in health-seeking behavior as a predicator for access and utilization of health services.

II. Provide in-depth procedures for problem identification in the delivery and uptake of health services.

III. Build the competence of the users in the implementation of the iDARE methodology.

[2] *Learning sites is an implementation approach that provides a platform for proof of concept for small-scale implementation and testing of SBC interventions.*

[3] *The Experience Lab is a venue for designing, testing, and adapting SBC interventions while providing implementing partners (IPs) real-time coaching and mentoring on implementing SBC at scale. It is led and run by Ugandan SBC experts in the academic, public, private, and NGO sectors.*

03 WHO IS THIS TOOL FOR?

The iDARE for SBC Activities Toolkit is intended to be a resource for deepening understanding and knowledge of GYSI and provide a practical implementation guide for both facility and community-based health workers to identify and address GYSI gaps impacting uptake of the desired behaviors. It shall be used by technical staff to design GYSI sensitive programming and monitoring and evaluation staff to develop indicators across development sectors.

04 WHY IS THIS TOOL IMPORTANT?

Gender, youth, and social inclusion determinants are some of the gateway factors that affect the adoption of the desired behaviors. Strongly entrenched cultural norms, practices, and beliefs, which are patriarchal and hierarchical with women and youth at the bottom of the hierarchy, influence the choices women and youth can make and, therefore, their behavior too. Men who are viewed as the heads of the household and gatekeepers for accessing healthcare and other services usually do not have the health information they need to make informed decisions and do not seek care for themselves, unless they are very ill, nor do they prioritize that of their household members. Other exclusion factors such as disability, ethnicity, sexual orientation, religion, displacement, and stigma, due to diseases, also affect engagement of audiences affected and their adoption of desired behaviors for optimal health outcomes. Awareness of these connections should inform the process of SBC interventions within the primary audiences.

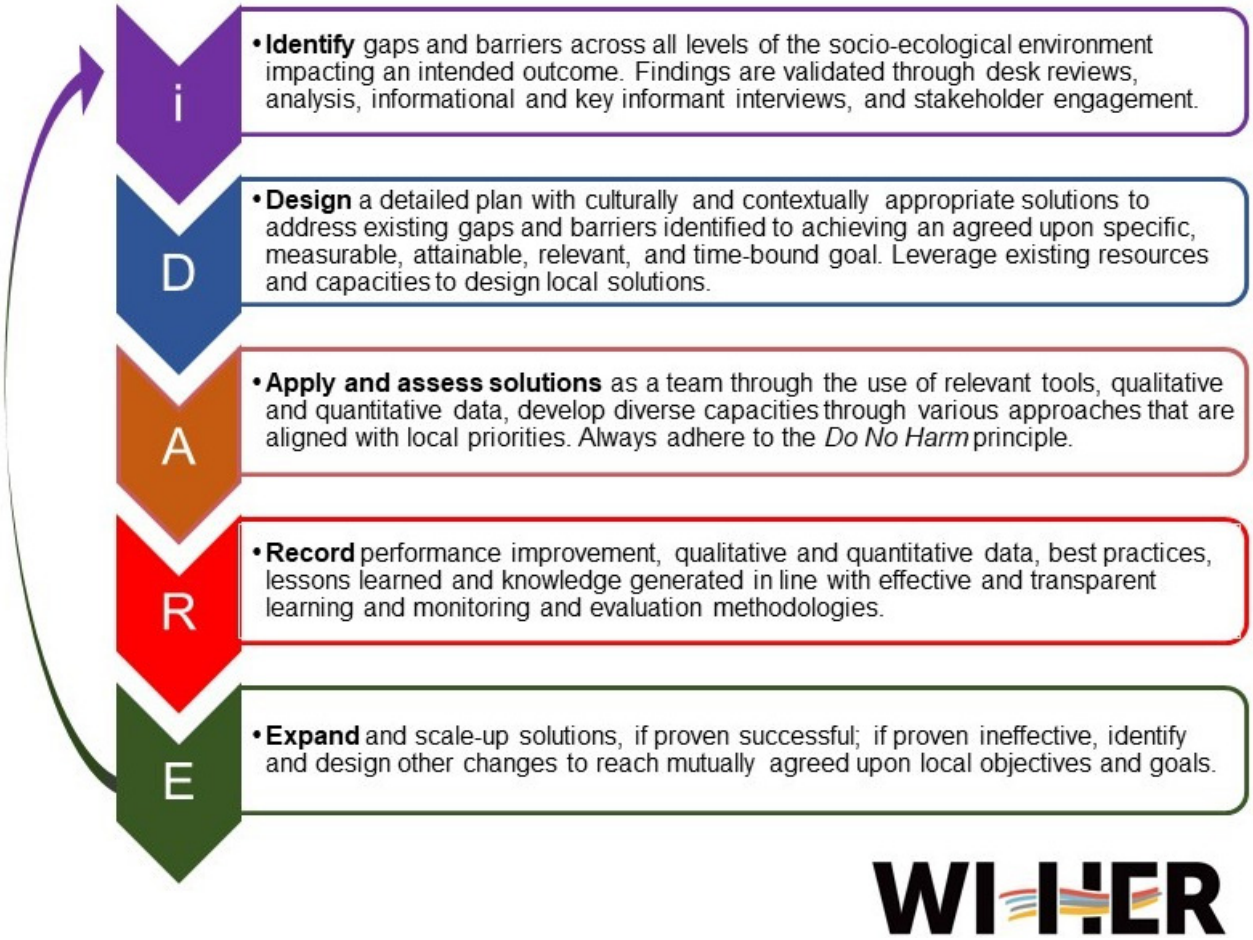
05 iDARE METHODOLOGY

The iDARE methodology (Figure 1) is results-driven, based on the science of improvement, and draws from classic theories and concepts, such as the Theory of Planned Behavior, the Social Cognitive Theory, and the Diffusion for Innovations as well as innovative approaches from parallel fields, including behavioral insight, behavioral economics, and marketing research.

iDARE is an improvement framework that provides a stepwise approach in the process of problem identification, co-designing solutions, application and assessment of the solutions, recording the observed changes and effects, and finally, expanding the successful solution (refer to the viral load suppression (VLS) change package in Annex G as an example).

The steps within the iDARE methodology are used to organize this toolkit, although they are not exactly presented the same way they are in the iDARE framework.

Figure 1. iDARE Methodology



06 HOW TO APPLY THE TOOLKIT

The iDARE for SBC Activities Toolkit includes a step-by-step process on how teams can integrate GYSI to improve outcomes by designing, implementing, and monitoring activities that have identified GYSI gaps, barriers, and/or issues and then address them within their broader programming. Each step builds upon the preceding step to develop feasible solutions to complex GYSI issues based on local needs, resources, and priorities. The toolkit should be tailored to a particular activity context and be adapted to the socio-cultural context.

This toolkit is organized through the lens of ongoing GYSI integration within the USAID SBCA project and therefore reflects SBC activities to increase health care utilization in Uganda. However, this example is one facet of the broader iDARE methodology, which has shown efficacy across developmental sectors and geographic locations. Therefore, the process will remain the same across all development sectors, but the tool will reflect the nature of the implementing program.

07 HOW THE TOOLKIT IS ORGANIZED

The tool is organized into the five major iDARE steps: identify, design, apply/assess, record, and expand. However, each of these five steps is broken down into smaller steps to make it easier for users to apply the toolkit.

SECTION II

STEPS FOR INTEGRATING GYSI INTO SOCIAL AND BEHAVIOR CHANGE PROGRAMS

STEP 1: IDENTIFY

Step 1.1 Identify the gap(s) impacting an intended outcome

- **Use quantitative and qualitative data** in the form of key informant discussions and observations and identify the process of care or the steps in place that lead to the target outcome.
- **Identify the behaviors that lead to positive or negative outcomes within the process of delivering services** (see Table 1 below for examples). This involves identifying the drivers for health outcomes. For instance, antenatal care ANC appointment attendance drives maternal and child health outcomes. Another example is antiretroviral therapy (ART); medication adherence and appointment-keeping drive VLS in HIV care. The behaviors at each level in the process of care directly impact the measured health outcome in the case of these examples; this means VLS for HIV-positive individuals and maternal and child health outcomes for pregnant women and their children. There are multiple levels in the process of service delivery for each health area, and each level offers a variety of opportunities to impact the health outcome, positively or negatively.
- **Look out for the GYSI-related factors to ensure inclusiveness in the process of service delivery.** This is done through a deep analysis of the program's qualitative and quantitative data forms.
- **Focus on equality, equity, and stigma.** When reviewing service delivery, focus on equality, equity, and stigma. Keep in mind that health behaviors may vary depending on the health area being addressed.

Table 1: Example of GYSI Barriers Across Health Areas

Health Area	level of Process of Care	Example GYSI Barriers and Behaviors	Health Outcomes
HIV	Condom Use	The imbalance in power between the sexes leads to women's lack of autonomy to control condom use.	Increased HIV incidence
	Voluntary Male Medical Circumcision (VMMC)	Gender norms around masculinity lead to a low rate of VMMC uptake. For example, the belief that circumcision reduces men's sexual urges.	Increased HIV incidence
	ART Adherence	Lack of parental support for youth leads to low appointment keeping	Low rates of VLS
		Men's work schedules interfere with appointment keeping	
Malaria	Use of Insecticide Treated Nets (ITNs)	Lack of information on the efficacy of ITNs use and care leads to low rates of usage among pregnant women and children under five.	High malaria incidence
	Early Treatment Seeking	Lack of financial resources in households leads to a low ability to seek early treatment	High malaria mortality rates
	Vector Control	Lack of household authority for women leads to low autonomy in seeking household vector control	High malaria incidence rates

Health Area	level of Process of Care	Example GYSI Barriers and Behaviors	Health Outcomes
TB	Early Treatment Seeking	Men's lack of time leads to delayed treatment seeking	High TB mortality rates
	Treatment Adherence	The long distance to the health facilities makes it difficult for the patients to access the facilities for their refills	High rates of resistant TB
	Rapid Notification	The nomadic population's lack of regular medical access and language barriers lead to delayed notification of TB status	High TB incidence
Maternal, Newborn, and Child Health	ANC Attendance	Cultural norms around early pregnancy disclosure leads to delayed ANC attendance	Poor neonatal outcomes
	Immunizations	Mothers living with physical disabilities are unable to bring their children for PNC immunization appointments, which leads to low immunization coverage	High measles incidence
	Postnatal Care (PNC)	Women lack financial resources to get to PNC visits for newborn babies, which leads to a lack of preventative care	High childhood mortality rates
Reproductive Health	Family Planning	Low usage of long-term contraception by rural women leads to a lack of adherence	Close birth spacing
	Family Planning method choice	Young women's lack of access to contraception leads to unplanned pregnancy and underage mothers	High infant mortality rates

Step 1.2 Determine the Problem and Magnitude

- After the process of care has been identified, **determine the magnitude of the problem impacting outcomes using the appropriate level of data to evaluate the extent of the gap.** The level of data will be context specific. If your primary audience is at the national level, looking at the national-level outcome data is appropriate. If your primary audience is in a catchment area or facility level, then the appropriate data will reflect that. Data sources may include existing program data, facility data, HMIS data, DHS data, or other routinely collected research data.

- **Conduct secondary data analysis to determine the GYSI determinants that are impacting the intended outcome.** Disaggregate data by sex, age, socio-economic factors, education, religion, or any other demographic criterion. An outcome gap may become apparent after data is disaggregated to understand gaps in groups or sub-groups of a population.

- **Determine where it is best to implement an intervention to impact the desired outcome based on the available data and priorities of the key stakeholders**. For the USAID SBCA project, healthcare facilities within learning sites are used as an entry point to the primary audience or community for SBC intervention aimed at unhealthy behaviors resulting from GYSI barriers. Successful programs are then shared back through the SBCA program and scaled to other facilities experiencing similar GYSI gaps. The implementation of the intervention will depend on the project scope and resources.

Step 1.3 Team Formation and Functionality

- **Form an iDARE team.** This team comprises a group of individuals with various perspectives and understanding of the problem determined in step two. Often this includes facility-based health workers and influencers from the community. It may also include a representative from the district local government, a village health team member, a representative from the regional IP, family members of primary audiences, and others. Influencers do not have a threshold of requirements; a mother or friend may be the primary audience's social and behavioral influencer.

- **Review data from the clients' interviews or any interactions with clients to identify individuals who are mentioned as their influencers.** These are the individuals who will best serve as community influencers. Always work with community members, leaders, and district-level administrators to identify individuals who are influencers within the community. Influencers are people who motivate primary audiences to drop undesired behavior and encourage desired behaviors. In some cases, the influencer may be someone who was not practicing the desired behavior but because of their influence in the community are supported to become an early adopter. Understanding influencers helps in determining agents of behavioral change that can impact health-seeking behavior for primary audiences. Influencers are identified by asking clients who influences their lives or whose word they respect and put into practice. Determining influencers is necessary for identifying an iDARE team to design and implement behavior change activities. Influencers should never be determined by anyone other than the clients/individuals who are being supported in behavior change.

Examples of influencers

- Religious/faith leaders
- Traditional/cultural leaders
- Community leaders
- Health workers
- Politicians
- Community-based organization agents
- Neighbors
- Shop owners
- Anyone identified by a client

Sample questions to identify influencers

- Which person(s) influences your decisions in life?
- Whose word do you respect and act upon in matters of health?

Contacting the identified influencers

- Contact potential influencers and encourage them to join the iDARE team for their community. Make sure the influencers consent to joining the iDARE team. The team should include at least two facility-based health workers. Past work demonstrates that approximately 10 members in total is a successful model for an iDARE team. Annex A is a form for the iDARE team roster for your usage per site.

Orienting influencers

- Once the team has been determined, orient them on GYSI concepts, the iDARE methodology, and the health area you seek to change. For example, if you want to improve viral load suppression, you will have to orient the influencers on HIV and the importance of VLS as an effective HIV response. This will enhance their capacity as influencers and prepare them for constructive interactions with their communities.

- **Orient the iDARE team on what is expected of them to ensure a clear understanding of their roles and responsibilities.** Emphasize that for the smooth running of the iDARE team, there is a need to:

    i. Identify a team leader who will manage the team and facilitate communication with the iDARE coach.
    ii. Hold regular meetings to review data and share progress and challenges faced during activity implementation.
    iii. Document minutes of all meetings as a basis for action.
    iv. Regularly update the iDARE journals to closely monitor the activity's implementation (Annex B).
    v. Document follow-on action plans to guide implementation.

Note: In preparing a physical or virtual orientation on GYSI concepts, it is essential to:

- Set up a convenient meeting place for participants, either at the facility or community.
- Develop and share an agenda ahead of the meeting.
- Contextualize the meeting materials such as PowerPoint slides (for example, use simple terms, avoid jargon, pictures, role plays, and other illustrations).
- Schedule the training in an appropriate format and at an appropriate date and time in agreement with the iDARE team.
- If the orientation is virtual, confirm internet availability for the team members, and familiarize them with the preferred application, e.g., Zoom.
- Conduct a pre-and-post orientation assessment to measure the level of knowledge.
- The orientation should aim to be participatory, either in-person or virtually.

Step 1.4 Identify GYSI Issues

In the first step of implementation, available demographic data is analyzed to determine the extent of the health outcome gap between sub-populations by disaggregating data according to GYSI criteria. One can see the impact of the GYSI gap, but you have not yet determined why there is a gap. You may have intuition, but it is crucial to get insight from those within the impacted populations.

It is time to **collect qualitative data by consulting the primary audiences** about which healthy behaviors are not practiced and their reasoning for not practicing the desired healthy behaviors. For example, we can see that HIV VLS differs between the sexes, but we do not know why. We begin by probing primary audiences at the site about their daily lives, issues that impact their health-seeking behaviors, and their family issue(s) affecting the desired behavior/outcome. The GYSI screening tool is included for further guidance (see Annex C).

In screening for GYSI issues, we attempt to determine the cause of the unhealthy behavior to design responsive interventions that address the root causes and ultimately improve health outcomes and reduce GYSI gaps.

Steps for screening for GYSI issues include:

i. Identify the primary audience. The client registers are the primary source of information.
ii. Ask the client to share factors preventing them from practicing the desired behavior (see Annex C).
iii. Ask the client about any issues affecting the desired behavior/outcome. These may include cultural norms, family issues, and gender related determinants.
iv. Document the GYSI related issues identified during the discussion.

A complete guide to identifying GYSI issues can be found in Annex C.

Step 1.5 Document the GYSI Issues

- **Assess the different issues affecting men, women, youth, and other potentially excluded sub-populations** in the health services provision process at the community and health facility levels. As you interview the primary audience, note the gender inequalities, constraints, and opportunities that affect behavior across the various categories of clients. During this process, some identified issues may be outside of the scope of GYSI, such as structural challenges and programmatic issues. However, these issues must still be addressed where possible.

- Through interactive discussion, **find out the different audiences excluded during the health services delivery processes.** For example, youth and adolescents are less likely to keep appointments for ART medication distribution. Furthermore, determine the patterns of gender issues hindering the practice of the desired behavior, such as gender-based violence (GBV) or limited power to make personal decisions.

- **Document all barriers to guide the process of co-creation of solutions.** Probe to understand the most common GYSI issues that impact healthy behaviors at each level in the process of care. A clear understanding of typical GYSI issues informs the type of interventions that will most impact the GYSI-related barriers to behavior change. Some GYSI barriers may be more common or less familiar; when designing interventions, it is crucial to focus on solutions with the highest impact.

GYSI issues may include:

- GBV made it difficult for the women to support their spouses in treatment adherence.
- Differences in roles and responsibilities made it difficult for the men to attend clinic days. For example, a number of men provide casual labor away from home and are paid per hour/day worked.
- Social exclusion issues, such as children missing appointments due to unsupportive caretakers who do not bring them to the facility. This can affect follow-up interventions.
- Cultural norms/beliefs, for example, the belief that ANC attendance in the first trimester causes miscarriage can hinder ANC attendance within the first 12 weeks of pregnancy.

A sample questionnaire used to identify GYSI issues can be found in Annex C.

Figure 2. Case Study – Identify

In Tororo District, a lack of social support was a barrier for youth who are living with HIV in maintaining their appointments and adhering to ART. To address this issue, an iDARE influencer worked with relatives and the local church to counsel on the importance of appointment keeping and ART adherence. This resulted in more support for the youth from within the family and church, which resulted in better appointment keeping, then more adherence to ART, and ultimately resulted in higher levels of VLS.

STEP 2: DESIGN

Step 2.1 Develop Social and Behavior Change Activities to Test

- **Co-design activities with the iDARE team members.** Start by reviewing the GYSI barriers you identified and documented in the previous steps, and let everyone think about ways to address these barriers. Some of the ways to address the barriers will have already been given by primary audiences during interviews to understand the barriers they face. Let team members brainstorm the solutions to the documented barriers and together select the most feasible ones in light of available resources and members' capabilities.

- **Develop indicator(s), both qualitative and quantitative, with the iDARE team to track and measure progress over time.** Qualitative indicators enable you to track changes in knowledge, attitudes, level of participation/involvement, satisfaction, etc., related to the solutions being tested. The team should work together to monitor the indicator they determined under DESIGN Step 1 based on the data reviews. An appropriate indicator should be:

    i. Valid: an accurate measure.
    ii. Reliable: consistently measurable in the same way by different observers
    iii. Objective: precisely defined in clear terms and uni-dimensional
    iv. Unambiguous: teams understand what the indicator means
    v. Measurable: quantifiable using available tools and methods
    vi. Relevance: Does the indicator significantly impact the programs or patients/clients in your clinic, network, or district?

- For each indicator, **establish baseline data and define the frequency of data collection.** Collect baseline data for at least four months before implementation. Determine appropriate intervals that may include days, weeks, or months (depending on the behavior). For Tororo District, in the implementation to improve VLS for those active in care, the indicator selected was to increase VLS of men and children from 63% to 95% by September 2021. Co-designing allows the team to plan activities within the community context and with the available resources. The following are examples of co-designed solutions from health workers, community influencers, and clients themselves for addressing GYSI issues that impact men and children to improve VLS among the men and children in care:

    i. Couple counseling for unsuppressed patients to encourage spousal support.
    ii. Home visits are supported by the next of kin to ensure adequate follow-up.
    iii. Formation of youth/adolescent support groups to support the youth and children on treatment.
    iv. Institution of viremia (non-suppressed viral load) clinics to provide peer support.
    v. Include the cultural gatekeepers (like cultural leaders and religious leaders) as influencers on the team.

- **Zone the Community and allocate tasks.** Determine how to split the catchment area into different zones and assign coverage areas to the iDARE team members. The zoning should consider the residence of the team member and the concentration of the primary audience, which may include men, children, women, and persons with disability, among others. Agree on the tasks that will be performed in the process of supporting the population.

Figure 3. Case Study – Design

After identifying the problem, the team of influencers in Tororo District brainstormed with the men, youth, and caregivers of the non-suppressed children to find out why they were not suppressing and co-create solutions. Some of the issues included a lack of food and child labor for the children, a lack of spousal support for the men to remind them to take treatment, and alcoholism among the men. It was agreed that home visits are conducted to counsel the spouses on the need for support to the men and peer counseling on alcohol taking, among others.

STEP 3: APPLY AND ASSESS

Step 3.1 Implement the Co-Designed Solutions

- After co-creating solutions and assigning responsibility, the team of influencers go to the implementation stage. Here, the iDARE team **starts working with the communities** to address the identified GYSI issues using the solutions that were co-designed with iDARE teams and community members, including members of the primary audience. The implementation process is supported through routine coaching and mentorship sessions using the WI-HER iDARE Coaching Guide (see Annex D).

Step 3.2 Monitor and Document Changes in the Desired Health Outcome

- **Support the iDARE team on a regular basis to review the progress** of activities and document trends in the indicator(s) using an appropriate method, such as a time series chart with annotations, which can be found within the iDARE journal (Annex B).

- **Agree on how often iDARE teams should meet;** this varies greatly depending on the team's goal and time to achieve the goal. However, it is recommended that the teams meet, at minimum, once a month. Team leaders, however, should check in at least once a week with their fellow team members to follow up on the implementation of the agreed-upon solutions.

- Each team member should **update the lead team member on their allocated task** and review data following the social and behavior change activities at each review meeting. The iDARE journal shows progress, including the data collected and critical lessons learned as a documentation process.

Step 3.3 Conduct Learning Sessions

- **Organize a learning session to create a platform for exchange and a critical review of the activities to date.** This will provide an opportunity to share learning, discuss challenges, and find solutions to the challenges raised by the team members. If multiple sites are conducting the implementation, it is best to use the iDARE teams from all sites so that learnings may be shared. It includes asking what worked, what did not work, why, and how. This discussion will help assess the application process to continually improve the implementation. It will help to determine which solutions should be explored as best practices and which solutions may need to be halted due to a lack of evidence.

- From the learning session, **use the lessons harvested to produce a change package** that will document stepwise approaches to promoting social and behavior change in the given context (see a sample change package in Annex G). These change packages may be shared with new sites to guide and inform potential solutions for similar GYSI gaps in similar health areas. It should be noted that solutions are highly contextualized for the site, and therefore it is important to use change packages as a broad guide, not direct instructions.

Figure 4. Case Study – Apply/Assess

At this stage, the team of influencers in Tororo District started conducting home visits, worked with the health facility at Nagongera to reinstate the young adolescent program, and set up clinic days for the non-suppressed clients, all geared towards providing social support for the clients. To support the children with food items, one of the influencers (a religious leader) set aside one Sunday every month to collect food items and meet with the children and caregivers to hand over the food and give spiritual counseling to the families.

STEP 4: RECORD

Step 4.1 Package solutions that work

In addition to using the iDARE journal by teams, learning sessions are a critical tool for recording successful and non-successful solutions. Learning sessions should support iDARE teams in recording critical information to develop packages of solutions that worked and did not work in their context.

i. Describe Solution

Each member should share what challenges their team addressed, change ideas/activities implemented, evidence that the change activities worked/did not work (baseline and follow-up), and describe how they implemented the change activities, including resources used/needed. Journals used during the implementation of change activities should validate each piece of information shared by the team/member of the team.

Challenge Addressed	Solutions Implemented	Evidence (Baseline and Follow-up)	Describe the Solution Implemented (Who, Where, How, Resources)

ii. Score Solutions

The rating should be based on the ease of the activity to implement, the ease of replication by others, impact on other behavioral change processes, and the impact the idea/activity had or did not have. The change idea/activity is rated with 1 'very low,' 2 'low', 3 'average,' 4 'high,' and 5 'very high.' When further clarity is needed to score the activity, a member or team should provide further insights. To assign a score, the team will collaborate to discuss the impacts and agree on the score together. The team should give reasons for the scores assigned after reaching a consensus.

Solution	Ease of Implementation	Easy to Replicate/ sustainability	Impact on Behavior Change	Total Rating

iii. Summarize Solution

Summarize the final change ideas that have been verified and validated following the scoring. Provide enough detail to allow adaptation across interventions.

Change ideas	
Change idea #	
Change idea #	

Figure 5. Case Study – Record

Using the documentation journals, progress on the implemented activities is recorded, and the different tested solutions are documented with the correspondence results.

The results are plotted on a run chart to clearly understand the observed trends and shifts during the onsite activities.

STEP 5: EXPAND

Step 5.1 Identify new areas, contexts, and/or teams to scale up iDARE efforts

When the team meets their original goal/ target that they agreed upon during the design stage, it is crucial to build on the momentum of the iDARE implementation and encourage the iDARE team to expand. This expansion may take different forms, such as:

- **Expand to more individuals** within the existing primary audience. For example, in Tororo district at both the Nagongera and Mulanda Health Centres, initial cohorts of men and children living with HIV who were active in care but had not reached VLS were identified to begin the implementation of the iDARE solutions. However, results were quickly positive, and expansion started by including the iDARE solutions for those outside the cohort.

- **Adopting a new indicator.** Once you see positive results, you may look back at the process of care and identify an additional target within the same health area. For example, in HIV, the process of care includes the end point of VLS; however, if you look back at the process of care, you may find that there is an issue with continuity of treatment, meaning individuals who have been tested and given a resulting positive diagnosis for HIV may not seek care. Therefore, another indicator within the HIV health area would be decreasing the percentage of those lost to follow-up. Additionally, activities that target continuity of treatment will feed into the original indicator of VLS.

- **Including another team for implementation** of iDARE in another health area. These health areas may be linked or unlinked. For example, family planning (FP) and MNCH are linked. Therefore, the make-up of the iDARE team and influencers may overlap, and activities that impact one will likely impact the other. Unlinked health areas could include TB and FP. The team of influencers and, therefore, the iDARE teams would likely be very different, and activities may not necessarily be linked. However, given the nature of SBC, increasing health-seeking behavior in one health area will often translate into another health area.

- **Identifying new sites in the same health area.** If your program is at the district level, this new site could be another facility; at the national level, it may mean a new district. Despite the location of the new site, it is important to build on the experience you have already developed. This can be done by having learning sessions between sites or sharing change packages that were developed from the experience at the initial sites. For a learning session between sites, sites with experience can walk through their complete iDARE process and share best practices and lessons learned. Change packages share much of the same information but in document form. However, it is crucial to go through the implementation process at each site. Context and resources vary between sites; therefore, all solutions must meet the needs, culture, and resources available.

Figure 6. Case Study – Expand

After learning and observing improvement in Tororo district at Nagongera and Mulanda Health Centre (HC) IV, the lessons learned were expanded to Kapchorwa to improve viral load suppression among the children and men at Kabeywa HC IV.

SECTION III

ANNEX A.
IDARE TEAM ROSTER

IDARE TEAM ROSTER

Site _____

iDARE Coach _____

Name	Title/position/role	Email Address and/or Phone Number	Village/Community

SECTION IV

ANNEX B. IDARE JOURNAL

IDARE JOURNAL

Region _____

District _____

Facility _____

iDARE Team Leader: _____

Start Date: _____ **End date:** _____

Part 1: Aim of Focus

State the aim of focus/objective (include targets and period)	Describe the root cause of the problem to be addressed	Tool used (Problem Tree – see annex)

Part 2: Indicators

For each aim, define the indicator that will be used to measure. Use this portion for your overall, aggregated indicator. Use part 3 to monitor the indicator disaggregated by age and sex, and any other relevant determining factor to understand closing of gaps in care and treatment among patients.

Objective	
Indicator	
Numerator	
Denominator	
Data Source	
Frequency of Reporting	

Part 3: Monitoring

For each indicator pick baseline data and then routine data over the period of testing improvement activities). Identify which indicator(s) will be disaggregated and how (by age, sex, or another determining factor). Adjust the template as needed to document disaggregated data for identifying existing and or additional gender, youth, and social inclusion gaps. Refer to the annex to see an example of how to track disaggregated data. The table can be adjusted as needed to document disaggregation at multiple levels.

		Indicator definition											
		Period (e.g, daily, weekly, monthly)											
		Baseline	Time 1	Time 2	Time 3	Time 4	Time 5	Time 6	Time 7	Time 8	Time 9	Time 10	Time 11
Indicator	N												
	D												
	%												

Part 4: Solutions Tested – Team Activities

List the changes that the team has tested to achieve the aim. Write all changes, whether effective or not. Also note when it was started and when it ended (where applicable) to enable you to annotate the results.

Planned and Tested Solutions: In the space below, list all the changes that the IDARE team will implement to address the objective. Use 1-2 sentences to briefly describe the tested solution.	**Start Date:** DD/MM/YY	**End Date** DD/MM/YY	**Effective? (Yes/No)** Was there any improvement registered?	**Comments**	**Responsible person on the iDARE team and Contact Information**
1.					
2.					
3.					
4.					
5.					
6.					

Part 5: Plot the Results

Title _____

Notes on the Indicator: Write down any additional comments you may have on the performance of indicators. Write anything derived from the change's worksheet and the graph template that might explain the performance trends of the aim. Include comments on gender, youth, and social inclusion gaps in the indicators that are being tracked. How have gaps shifted in the indicators?

Part 6: Lessons Learned

Write here any effects (positive or negative) you are currently observing as a result of the IDARE team effort such as comments from patients, changes in your performance or motivation, efficiency or the survival story of a client/patient

Annex: Disaggregated data table

<table>
<tr><td rowspan="7">Indicator</td><td colspan="23">Indicator definition</td></tr>
<tr><td colspan="23">Period (e.g, daily, weekly, monthly)</td></tr>
<tr><td></td><td colspan="2">Baseline</td><td colspan="2">Time 1</td><td colspan="2">Time 2</td><td colspan="2">Time 3</td><td colspan="2">Time 4</td><td colspan="2">Time 5</td><td colspan="2">Time 6</td><td colspan="2">Time 7</td><td colspan="2">Time 8</td><td colspan="2">Time 9</td><td colspan="2">Time 10</td><td colspan="2">Time 11</td></tr>
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<tr><td></td><td colspan="4">Analyze findings by age and document the findings in the space on the right, i.e.
10-14
15-19
20-24
25-29
30+</td><td colspan="19"></td></tr>
</table>

SECTION V

ANNEX C.
iDARE QUESTION GUIDE

UNDERSTANDING GENDER YOUTH AND SOCIAL INCLUSION ISSUES IMPACTING HEALTH SEEKING BEHAVIOR

Step 1:

Identify the problem

Step 2: Screen for GYSI issues

a. Line list clients with the identified problem
   - Check district data to identify group of people (at least 30) in same "group"
   - Compile list of individuals with name, sex, contact information / home

b. Decide on mode of engagement for one-on-one private conversation with people identified (and potential cohort members). For example:
   - Ask health workers / VHTs to take you to the homes of the individuals
   - If anyone is too far, then we need to identify another means to contact them (for example, during an ANC day)
   - Through religious/community leaders (especially for out of school youth)?

c. Introduce yourself to the individual "client" and request consent to ask them questions about them (interests, opinions) including on health.

d. After greetings and niceties, begin the informational interview. Ask the client the background following questions:
   - What is your age?
   - What is your occupation?
   - What is your marital status? (Married or cohabitating with a partner living in same household; married or cohabitating but partner is temporarily away; in a relationship but do not live together; not in a relationship single; divorced/ separated; widow/widower; child)
   - Take note if the client is male or female.
   - Does the client have a visible disability?

e. Seek the client opinion about the potential reasons (influencing factors) for why they are (INSERT ISSUE/ PROBLEM)
   - Where applicable, consider using below statements with 3-point Likert scale during the discussion with the client, or asking in a question and probing for further information.

f. General knowledge/ attitude of health care system
   - When you or a family member get sick, what is the first action you take? Who do you call or visit?
   - Who do you seek advice from? (financial/business, life, romantic, health, or other advice).
   - What is your nearest health facility? When did you last go to the facility? For what?
   - Was your experience positive or negative at the facility? Why?
   - Is there a person in the family who normally goes to the health center for the rest of the family, or does everyone seek their own care and attend their own appointments?

g. COVID knowledge, beliefs, perceptions, attitudes
   - Have you heard of COVID-19? What is it? Who/where did you receive information from (friend, neighbor, family member, radio, newspaper, community member, health facility, etc.)?
   - Have you, or do you know anyone who had COVID?
   - Have you needed to visit the facility during COVID? Did you go? Why/why not?
     - » If yes, what was your experience?
   - Have the lockdowns impacted you and your family? How? (probe for health impact/illness and or death, financial, movement etc.)

h. Knowledge of health area:
   - What do you know about XXX (HEALTH BEHAVIOR/ ISSUE)?
   - NOTE: If client does not know about XXX, change the below questions to general medication for an illness to get an understanding of perceptions, beliefs, attitudes and opinions on overall health prevention and treatment.

- If client responds no, this is a barrier to be listed on **root cause analysis form section 2**
- (Depending on focus group outcomes/existing information, a few knowledge-related items related to popular myths – if this is an issue - could be asked here)

i. **Attitudes towards the behavior** (comprised of outcome expectations and behavioral beliefs)
- What do you think will happen if you do XXX BEHAVIOR?
- What do you know or have heard about its outcomes (if the person mentions any perceived outcome, probe how)?
- Probe on what specific outcomes one has heard that relates to her/his gender [what outcomes would a man/woman experience, why do you say so? Have you seen any person with these effects?]
- What are you told about XXX ISSUE? Who tells you, e.g., mother-in-law, traditional healer? Where were you told this information e.g., at coffee, at a women's meeting, or by the village broadcaster?
- Outcome expectations (what will happen if they do the desired behavior) i.e., "If I do XXX, I will (INSERT POSITIVE STATEMENT), 1= disagree, 2= unsure, 3 = agree, or "If I take XXX, I may experience bad side effects, 1= disagree, 2= unsure, 3 = agree)
- Behavioral beliefs (positive/negative evaluation of behavior) i.e., "When it comes to INTENDED HEALTH OUTCOME, doing INTENDED BEHAVIOR is, 1= bad, 2= not sure, 3 = good)

j. **Perceived risk/threat of XXX** (comprised of perceived susceptibility and perceived severity)
- How concerned are you about XXX? What concerns you the most?
- Perceived susceptibility - i.e.,"I worry about the possibility of NEGATIVE HEALTH OUTCOME" 1= disagree, 2= unsure, 3 = agree
- Perceived severity - i.e.,"I am afraid of even thinking about INTENDED BEHAVIOR" 1= disagree, 2= unsure, 3 = agree
- Do you associate any form of abuse to making decisions about INTENDED BEHAVIOR?

k. **Perceived norms** (comprised of descriptive norm "beliefs about what most others do" and injunctive norms "motivation to comply")
- Do you know of other people who did not participate in XXXX (men/women – colleagues)? What are the reasons people don't participate? (Probe for: being away due to work/livelihoods, opportunity costs of going, not being able to attend because the VHT is not a woman etc.)
- Do other men and women have different views about XXX INTENDED BEHAVIOR? Do you feel that they have better access and or support than you?
- Descriptive norms: i.e.,
- "In your opinion, how many people in your community DO THE INTENDED BEHAVIOR? 1 = none, 2=unsure, 3 = everyone
- "Most people like me INTENDED BEHAVIOR last year/last time. 1 = disagree, 2=unsure, 3 = agree
- "Most people who are important to me (such as my partner, family, and friends), DO INTENDED BEHAVIOR." 1 = disagree, 2=unsure, 3 = agree
- Injunctive norms: i.e.,
- "Most people who are important to me (my partner, family, and close friends) think I should DO INTENDED BEHAVIOR." 1 = disagree, 3= unsure, 3 = agree
- "When it comes to HEALTH OUTCOME, I want to do what my partner/family/close friends think I should do." 1 = disagree, 2=unsure, 3 = agree
- During COVID I am "1= more likely to DO INTENDED BEHAVIOR; 2= same likelihood of DOING INTENDED BEHAVIOR; 3= less likely to DO INTENDED BEHAVIOR"

l. **Perceived Behavioral Control** (overall measure of perceived control over the behavior):
- Who decides if you take medication or seek care and treatment? Probe for whether the respondent perceives that they have control over whether or not they take medication or seek care
- To what extent is financial capacity a factor to your decision about taking medication and or seeking care and treatment?
- Who influences you? Probe for nuclear and extended family members, husband/wife; friends, neighbors, leaders, media, politicians, others. Probe for how they are influenced - i.e., how and when they interact with their influencers.
- Are you married? Have a partner? Do they DO INTENDED BEHAVIOR?
- i.e., "INTENDED BEHAVIOR is completely up to me," 1 = disagree, 2= unsure, 3 = agree. "I am confident I can DO INTENDED BEHAVIOR, 1 = disagree, 2= unsure, 3 = strongly agree)

m. **Previous behavior:**
   - What is the main reason for not DOING INTENDED BEHAVIOR?
   - Have you ever in the past DONE INTENDED BEHAVIOR? If yes, the last time you did – what was the main reason you did? Did you hesitate? Please describe. What is the one thing that nearly stopped you from DOING INTENDED BEHAVIOR? What has changed?

n. **Opinions about VHTs and services offered**
   - What do you think about the VHTs in your community? How knowledgeable and skillful do you see them to be? Do you think that male or female VHTs are equally effective? Why or why not?
   - Would you prefer to receive medications and or health advice / information from a male or female VHT? Why or why not?

Step 3:

Document the information shared in Steps 1 and 2 using the root cause analysis tool Sections 1,2, and 3.

Step 4:

After the interview, analyze who the client mentioned as key individuals in their life (influencing their behavior and or decisions) to determine layers of influencers for the clients interviewed in Section 4 of root cause analysis tool.

Step 5:

Form cohort of people (ideally 30 people) who will be first supported in behavior change efforts (section 4 of root cause analysis tool).

- People need to be willing to participate and consent

Step 6:

Recruit client-identified influencers (root cause analysis form section 4) to join iDARE team.

Step 7:

Use the iDARE journal and begin working with influencers to support behavior change of cohort

- Train team leader and team members, including influencers on iDARE and GYSI
- Provide coaching to iDARE team on regular basis
- Measure progress against set indicator
- Track progress using iDARE journal

SECTION VI

ANNEX D. COACHING GUIDE

iDARE COACHING GUIDE FOR LEARNING SITE TEAMS

1. GENERAL INFORMATION

Learning Site Name / District and Region: _____ Date: _____

Coaches:

No.	Name	Workstation	Telephone
1.			
2.			
3.			

Names of district/ learning site personnel attending meeting with coaches:

Surname	Other Names	Job Title	Responsibility in DHT/ learning site team	Telephone	E: mail

Key tools to review

- Previous visit site action plan
- Documentational Journal to ensure its updated.
- iDARE team previous minutes

2. STATUS OF iDARE FACILITY TEAM:

2.1.1 Number of iDARE team meetings held since last site visit (or any other meeting where use of iDARE methodology were discussed to address GYSI issues impacting on health outcomes) Check for minutes.

2.1.2 Did the team test any Designed intervention in the last action period? (A functional iDARE team is one that has identified a quality gap, has current action plan with regular data collection to monitor progress). Review and update the Journal with the data.

2.1.3 Are the team members assigned roles that they are actively functioning? (Current action plan may be useful to revamp).

2.1.4 Difficulties and constraints with regards to team functionality (a functional iDARE team is one that has identified a quality gap, has current action plan with regular data collection to monitor progress).

2.1.5 Proposes solutions to overcome these constraints.

2.1.6 Are there any external factors affecting the iDARE team? Record the factors and the date(s) affected. (e.g., COVID-19, health worker strike, weather event, lack of supplies, laboratory closure)

3.0 REVIEW iDARE DATA

3.1.1 Review the data in the iDARE journal. Take a photo of the data or make a copy of the data for your records and discuss the meaning of the different trends being observed from the data.

3.1.2 Are the data disaggregated by any groups (e.g., sex, age, trimester of pregnancy)? If yes, are there any differences in the data based on the disaggregation? If no, is there a need to disaggregate data?

3.1.3 Are there any missing data points? Work with the team to record these data during the visit. If the data is not accessible, what is the plan to get the missing data?

3.1.4 Are there any challenges in accessing data? What are they?

3.1.5 How does the team plan to overcome challenges in accessing data?.

4.0 DEVELOP ACTION PLAN FOR CURRENT/NEXT MONTH

(Do not wait for the end of the meeting to fill the action plan template as throughout the discussion, the team will be making suggestions and plans you need to write them as you go along)

Action plan development

No	Gap to be addressed	Activity	Person Responsible	Time Frame	How will you know/verify that gap has been addressed?

SECTION VII

ANNEX E. GLOSSARY OF KEY TERMS

Equality, or gender equality:
Is the absence of discrimination affording women and men equal access to human rights, socially valued goods, opportunities, and resources,

Equity:
Refers to the fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

Gender:
Is used to describe the characteristics of women and men that are socially constructed, while sex refers to those that are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behavior makes up gender identity and determines gender roles.

Gender Blind:
is used to refer to interventions that fail to recognize gender dynamics and their effect on development outcomes and goals.

In contrast, gender aware interventions actively seek to identify and integrate activities that address the role of gender dynamics to achieve better outcomes.

Health communication:
Is the study and use of communication strategies to inform and influence individual and community decisions that enhance health. Health communication considers a variety of channels to deliver its targeted or tailored messages to specific segments among varied audiences, including individuals, communities, health professionals, special groups, and decision makers.

Health promotion:
Is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.

Influencing factor:
Health is influenced by many factors, which may generally be organized into five broad categories known as determinants of health: genetics, behavior, environmental and physical influences, medical care and social factors

Influencer:
Is an individual who influences perceptions, beliefs, attitudes, opinions of primary, secondary, and or tertiary audiences.

Sex:
Are the biological traits that societies use to assign people into the category of either male or female, whether it be through a focus on chromosomes, genitalia or some other physical ascription.

Socio-Ecological Model:
Considers the complex interplay between individual, relationship, community, and societal factors. This model focuses on integrating approaches to change the physical and social environments rather than modifying only individual health behaviours.

Social and Behaviour Change:
Addresses knowledge, gender, social, and cultural norms and enabling environment that impacts health-seeking behaviours in persons and communities. Social and behaviour change can impact health outcomes by changing, over time, the gender, social, and cultural norms, as well as attitudes, beliefs, perceptions, and practices around health and overall decision-making.

Social and Behaviour Change Communication:
Is an evidence-based, theory-driven process that uses communication to identify and address such factors, and positively influence individual and collective behaviors to improve health outcomes.

Social Determinants of Health:
Are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

Social inclusion:
Is the process of improving the terms on which individuals and groups take part in society—improving the ability, opportunity, and dignity of those disadvantaged on the basis of their identity.

Social exclusion:
Describes a state in which individuals are unable to participate fully in economic, social, political, and cultural life, as well as the process leading to and sustaining such a state.

Sub-population:
A part or subdivision of a population, especially one originating from some other population. Defined as a group of individuals within a wider population who share certain key characteristics, for example socio-demographic characteristics or shared interests, activities, perceptions, and beliefs. A subpopulation can include any amount of people, more than one.

Youth:
According to the Uganda National Youth policy refer to all young persons, male and female, between the age of 12 to 30 years.

Vulnerable Populations:
Include children, pregnant women, elderly people, malnourished people, and people who are ill or immunocompromised, and are particularly vulnerable when a disaster strikes, and take a relatively high share of the disease burden associated with emergencies. Poverty – and its common consequences such as malnutrition, homelessness, poor housing, and destitution – is a major contributor to vulnerability. It also includes exclusion, or the denial of social and economic opportunities to an individual or group.

Vulnerable Youth:
Refer to individuals who bear the double risk based on their age and another vulnerable individual characteristic.

SECTION VIII

ANNEX F. PROBLEM TREE WORKSHEET

Resource description:
This worksheet guides the facilitators and the participants to understand the causes and consequences of the problem to clearly co-create possible solutions.

Activity overview:
This exercise will help your team explore underlying issues related to health system functions that can affect specific health outcomes of interest.

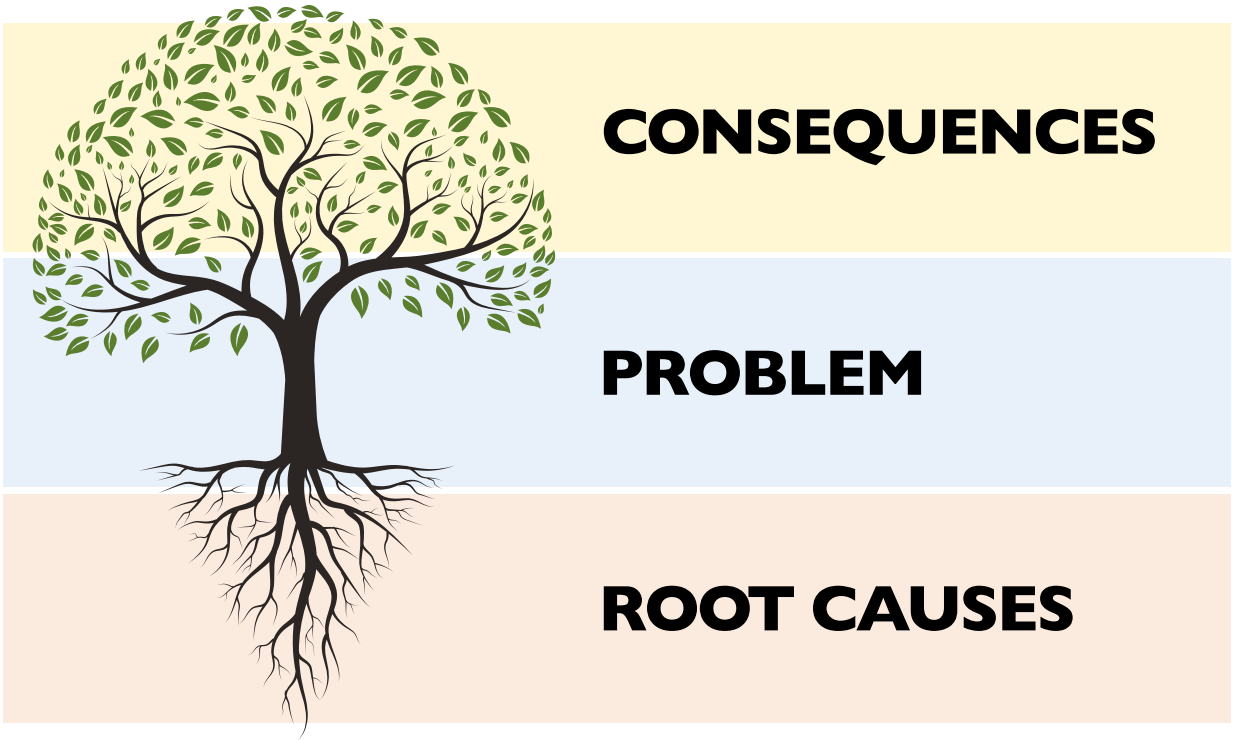
As a group, draw an example of a problem tree based on the description given below. The problem tree should depict both the causes and consequences of this problem.

1. Draw a large tree trunk and write your assigned problem on the trunk. This picture represents a "problem tree" and it will graphically help to illustrate the different causes and consequences of your assigned problem.

2. Brainstorm some of the consequences of your assigned problem. This can be as broad or as narrow as your group desires. On the problem tree, each consequence should be shown as one of the branches of the tree. After mentioning each consequence, think about what else can contribute to that initial consequence, these can be drawn as branches off the main branches. For example: The problem can be "high maternal mortality rate", a consequence might be low rate of breastfed children, and an off branch could be child nutrition rates lowering.

3. Now focus on identifying the different causes of your assigned problem. In your picture of a problem tree, the causes will be depicted as the roots of the tree. As you did with the consequences, brainstorm and identify the causes of your assigned problem. For example: The problem can be "high maternal mortality rate", and first set of causes can be a) poor access to skilled care; b) poor quality of care; c) poor management of third stage of labor. Then you should consider the "why?" underlying each of these causes and extent the roots further. Why is there poor access to skilled care? Perhaps because there are (i) shortages of skilled birth attendants, (ii) many expecting mothers live far from properly staffed facilities, and (iii) fees for delivering at such a facility are prohibitive for many. You can continue asking "why?" until you feel you've identified the root causes that can be reached with interventions.

4. Once you are done, please use a different colored marker and circle the causes and consequences of your assigned problem that are in any way related to the health system functions and gender and social inclusion.



SECTION IX

ANNEX G. VLS CHANGE PACKAGE

01 INTRODUCTION

This change package has been developed with the support of USAID through the Social Behavior Change Activity (SBCA), led by Johns Hopkins Center for Communication Programs (CCP) in partnership with WI-HER, The Medical Concierge Group (TMCG), The Busara Center for Behavioral Economics and World Vision, Inc. Since 2020, SBCA has supported regional implementing partners (IP), local district governments, and facility teams in the implementation of social and behavior change activities in order to reach national health targets. The data informing this change package came from Tororo District where the project implemented social and behavior change activities along with the IP, Regional Health Integration to Enhance Services in Eastern Uganda (RHITES E), the Tororo district health team, and the iDARE teams from Nagongera Health Centre (HC) IV and Mulanda HC IV in order to meet the target for viral load suppression (VLS) along the 95-95-95 targets for epidemic control for HIV. Further evidence from the SBCA scale up, through RHITES-E, was added into the change package from Kapchorwa district.

The team gathered evidence through the implementation of WI-HER'S identify, design, apply/ assess, record, and expand (iDARE) methodology. This is a methodology applied to address gaps, including gender equity and social inclusion gaps through improvement and behavior change sciences. Community influencers, that clients themselves selected, were brought on as iDARE team members to support and foster behavior change among men actively enrolled in care (above 20 years) and children (age 0 – 19 years) in order to address gender, youth and social inclusion (GYSI) issues impacting health outcomes for VLS. The change package describes implementation of solutions aimed at closing GYSI barriers to care, with a foundational principle of "DO NO HARM." The process starts with identification of GYSI gaps, designing and applying interventions aimed at addressing root causes of GYSI gaps, in order to increase health seeking behavior and improve health outcomes. Accessing the recorded data for the best practices and lessons learned enabled the IP to expand implementation of iDARE methodology to other SBCA learning sites, such as Kabeywa Health Center III in Kapchorwa District.

The project supported development of this change package while iDARE teams implemented solutions to GYSI gaps in Tororo and Kapchorwa districts. The aim of this initial experiment was to address disparities in VLS among men, youth and children sub-populations, respectively. Both initial sub-populations were HIV positive and actively in care but had not reached VLS. It was hypothesized that as the disparities in VLS were based on gender, youth, social and cultural norms, specific targeted solutions would address the barriers unique to these sub-populations, that in turn would increase antiretroviral (ART) adherence and lead to increased rates of VLS for the primary audiences. iDARE teams from Nagongera Health Center IV started the implementation in August 2020 and assessed the level of achievements and recorded all the gains and challenges in the iDARE documentation journal. The high-impact changes were then used to expand the work to the second facility, Mulanda Health Center IV and in Kabeywa Health Center III.

02 RATIONALE FOR CHANGE PACKAGE

The solutions have been tested and the best practices and lessons learned can be found in the change package table below (Table 1). The change package is intended to act as a guide for iDARE teams at new implementation sites. The new implementation site may look at the history of solutions and outcomes from other implementation sites in order to learn about potential solutions that have been used to address similar GYSI issues. This change package provides new sites with a stepwise approach to implementation for each solution. This document captures all solutions, whether effective or not, in order to inform all new implementation sites with historical insights. It is important to note, however, that GYSI issues will vary based on context, culture, and other factors. A solution may not work from context to context and should be adapted accordingly, always adhering to the principle of DO NO HARM.

03 EXPECTED USERS OF THE CHANGE PACKAGE

- New implementing districts and implementing partners may utilize the change package to spread gains and avoid missteps.

- Health care providers in Tororo and Kapchorwa Districts (Nagongera, Mulanda and Kabeywa health facilities) may utilize the change package for expansion to other health thematic areas or for additional male and children clients enrolled in care.

Table 1: iDARE Methodology Change Package for Viral-Load Suppression among Men and Children

iDARE Target	GYSI Gaps identified	Solutions Tested	Did the Solution work?	Evidence	How to Implement
Increasing viral load suppression among men active in care	Excessive alcohol and smoking associated with non-suppression status (In some cases, led to gender-based violence)	Assigned community influencers to provide home-based couple counseling to clients	Y	At Nagongera HC IV-From September 2020, baseline data 65% to March 2021, 84% VLS.	• The site formed iDARE team and assigned roles to all team members (this team comprises of community influencers[See iDARE for Social and Behavior Change Toolkit for additional information on community influencers] and health workers). • The iDARE team held a meeting with identified community influencers. • The iDARE Nurse in the ART clinic (iDARE team leader) at the facility listed the non-suppressed men and children per village for follow up. • Assigned clients to community influencers that the clients themselves suggested during interactions to understand the barriers they faced. • Following their orientation and action planning, influencers conducted home visits to their assigned clients. • Community linkage facilitators (influencer) spoke directly to the client taking excessive alcohol and smoking and encouraged them to take less alcohol and smoke less. • Scheduled a day to meet once a week (Fridays) to speak with them about the dangers of excessive alcohol and smoking

	Missed appointment keeping and adherence to ART medicines	Conduct home visit to next of kin for clients who had missed appointment	Y	From 66% in Sept 2020 to 77% in Dec 2020 (at Nagongera HC IV) Kabeywa HCIII March, 2021 69% to 90 July, 2021	• iDARE team meeting to identify clients who had missed appointment • Influencers were assigned clients per respective villages to follow up • Influencers attempted to contact clients through their next of kins
	Men sending their wives to facility for ART appointments, resulting in missed adherence counseling, health education, nutrition assessment and counseling, etc	Established designated non suppressed clinic days for men and children	Y	From 77% in Dec 2020, to 81% by end of Jan 2021, achieved 84 % by end of March 2021 at Nagongera HC IV. At Mulanda HCIV, from 73% in February 2021, to 96% by end of April 2021	• Team meeting to identify specific days for offering services for non-suppressed clients. The health workers harmonized this by matching the next appointment date given to every non suppressed client to agreed days. • Team retrieves the client files a day prior to scheduled clinic day to reduce on waiting time. • The community influencers conduct health education sessions. • Team offers individual supportive /on-going counseling for the clients (case-by-case)
Increasing viral load suppression among children active in care	Lack of family support from the guardian (The guardians do not remind the children of the time for taking medicines, they do not accompany them to the clinic for refills, -children are left alone to manage their treatment plans)	Assigned pastor and one community influencer to follow up and support children living with non-suppressed HIV and their families	Y	Nagongera HC IV from September 2020, 68% to 77% in Dec 2020 This change worked well in Nagongera HC IV but did not work very well at Mulanda HC IV	• Pastor and 2 community influencers conducted outreach sessions to identify and counsel the children's caregivers. • iDARE team held community dialogue with caregivers to establish a sustainable treatment plan. • Identified a treatment buddy to remind and support the guardians to monitor child's adherence to ARV Medicines. • Pastor and influencers offer on-going supportive counseling to children and caregivers during children clinic days

	Lack of food for children, leading to low ART adherence	Pastor offered food package on monthly children clinic days	Y	December 2020, from 77% to 82% in Feb 2021at Nagongera HC IV This change worked well in Nagongera HC.	• The Pastor and church council committee designated the third Sunday of the month for the congregation to collect special contribution to support the children living with HIV • Pastor and the team established a day in a month to deliver the food items and distribute the items to children at clinic
			N	Change did not work in Malanda HC IV.	• The religious leader of Mulanda was not able to mobilize food and neither was he as active in the community as the religious leader of Nangogera. • In Nagongera the religious leader was selected by the caretakers of the children while in Mulanda the religious leader was contacted purposively by the health facility on learning of the successful intervention from Nagongera. • The process did not therefore fully involve the intended audience and the selected religious leader did not have the same motivation as the one in Nagongera.
	Children subjected to hard labor, associated with low adherence and low appointment keeping	Established Young Adolescent Peer Supporters (YAPS) to offer counseling session to children and caregivers during clinic days	Y	From Feb 2021 Mulanda HCIV team gained from 67% to 92% by May 2021. Meanwhile Nagongera team gained from 75% in February 2021 to 81% by end of May 2021 Kabeywa HCIII, from March 63% to July at 88% in VLS	• The YAPS (adolescents on ART who adhere to the treatment and are able to give life testimonies on themselves) come to the clinic on designated days to conduct focus group discussion with children (age 10-19) (generate discussion topics such as "what reminds you to take your medicines every day". • Provide a child friendly environment, engage children in plays as they wait for their refills.

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ADDITIONAL LINKS

Applying the iDARE Methodology in Uganda, Kenya, and Tanzania to Improve Health Outcomes During the COVID-19 Pandemic

Improving Viral Load Suppression Among Men and Children Active in Care Through Community-Designed and Led Solutions: Protocol for Retrospective Closed Cohort Study in Eastern Uganda

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