



Mapping the evidence on social, behavioural and community engagement for reproductive, maternal, newborn, child and adolescent health

Social, behavioural and community engagement (SBCE) interventions support and strengthen the capabilities of individuals, families, communities and health services to identify and respond to the health needs and well-being of women, children and adolescents. SBCE covers a range of approaches, including interpersonal communication, health education, and mass and social media. It also addresses financial barriers to health, community mobilisation, and community participation in health planning and programming.

In the era of the Sustainable Development Goals, the Every Woman Every Child movement and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) call for action towards three objectives:

- Survive (end preventable deaths);
- Thrive (ensure health and well-being); and
- Transform (expand enabling environments).

SBCE interventions are increasingly recognised as an integral component of strategies to reach these global objectives.

To support investment in and the implementation of effective and sustainable programmes, decision makers need access to evidence on intervention effectiveness. SBCE interventions have a limited global evidence base, although it is growing. Improving the availability of existing evidence will help stakeholders to draw on current knowledge and to understand where new research investments can have the greatest impact.

To support the strengthening of access to the SBCE evidence base for reproductive, maternal, newborn, child and adolescent health, the World Health Organization (WHO) commissioned this brief to synthesise the findings from two evidence gap maps (EGMs): one on [reproductive, maternal, newborn and child health \(RMNCH\)](#) and one on [adolescent sexual and reproductive health \(ASRH\)](#).

This brief highlights the main findings and commonalities related to SBCE interventions across the two EGMs and summarises areas for future research. Detailed descriptions of the inclusion criteria, methodologies and findings of each map can be found in the respective reports.

What is a 3ie evidence gap map?

3ie EGMs are collections of impact evaluation and systematic review evidence for a given sector or policy issue according to the types of programmes evaluated and outcomes measured. They include an interactive visualisation of the evidence base, displayed in the framework of relevant interventions and outcomes. By highlighting where there is a lack of impact evaluations, or where there is a need for systematic reviews or reviews of better quality, EGMs help decision makers target their resources to fill important evidence gaps. They also facilitate evidence-informed decision-making by making existing research more accessible. Accompanying EGM reports focus on evidence characteristics rather than study results.



istock.com/Hadyryah

Main findings – Reproductive, maternal, newborn and child health

The EGM on selected SBCE interventions for RMNCH (Figure 1) identified impact evaluations and systematic reviews of effectiveness on selected health areas:

- Reproductive health interventions that address the timing and spacing of pregnancies;
- Maternal health interventions that address pregnancy, childbirth and 28 days after birth;
- Newborn health interventions that address from birth up to 28 days after birth; and
- Child health interventions that extended after the newborn period to 10 years of age.

The box on page 4 outlines specific health topics covered by the map. The EGM includes 457 completed and 38 ongoing impact evaluations and 142 completed and 13 ongoing systematic reviews.

Impact evaluations

Impact evaluations are unevenly distributed across intervention areas. There has been a heavy focus on studies of interpersonal communication and health education activities for all RMNCH areas ($n = 244$), specifically home visits and group-based education approaches. Demand-side financing and community mobilisation interventions are also commonly studied. We found relatively few studies that evaluate mass and social media activities and education entertainment, m-health, social marketing, or community-based health insurance. Evaluations of programmes to promote community participation in health service planning and programmes and social accountability are also less common ($n = 6$).

Most studies focus on child and infant feeding and nutrition ($n = 195$) and care during pregnancy and childbirth, and after childbirth ($n = 131$). A smaller number of studies target the other nine health topics in this map, such as immunisation, healthy timing and spacing of pregnancy, water, sanitation and hygiene, and early child development. There are also a few studies of SBCE interventions targeting pneumonia.

Most studies assess effects on health-related outcomes, such as mortality, morbidity, care-seeking and home care practices. This reflects the focus of the UN Millennium Development Goals on mortality and care-seeking, which coincided with the period covered by the search strategy (2000 to 2016). Few studies measure outcomes associated with an enabling environment, such as health provider attitudes ($n = 7$) and communication skills ($n = 15$), household communication ($n = 18$), changes in social norms ($n = 5$), and perceptions of quality of health services ($n = 17$). A small number of studies measure the broader social outcomes aspired for under the new Global Strategy for Women's, Children's, and Adolescents' Health, including community participation in health ($n = 3$) and social accountability ($n = 3$).

A number of sub-populations and geographical areas are not considered in the included impact evaluations. Relatively few studies incorporate gender or equity questions or analysis. For example, few studies assess gendered effects on marginalised populations such as by looking explicitly at ethnicity, culture, sexuality or sexual orientation, or people living with disabilities.



Stephan Gladieux/World Bank

Most studies took place in Sub-Saharan Africa and South East Asia, reflecting the highest regional burdens of maternal and neonatal and child mortality. Over half of the studies (n = 270) come from just 10 low- and middle-income countries: Bangladesh, Brazil, China, Ghana, India, Kenya, Mexico, Pakistan, South Africa and Uganda. There are some countries with a high burden of maternal and infant mortality where we identified no studies, particularly in West Africa.

The design and reporting of existing impact evaluations limit what we can learn from these studies, which also negatively affects the usefulness of subsequent systematic reviews. We identified a surprisingly large number of randomised controlled trials (76% of included studies). They are valuable because they allow identification of attributable effects of interventions on defined outcomes. However, few utilised a mixed-methods design or reported cost information. Their usefulness is therefore limited, as they do not address related questions, such as who is affected by the intervention, how, why and at what cost.

Moreover, the team noted a lack of detailed reporting on interventions' design and implementation, which limits what we can learn from the studies and negatively affects the feasibility and usefulness of synthesis across studies.

Systematic reviews

Systematic reviews are unevenly distributed across intervention areas, largely reflecting the impact evaluation literature. The intervention category that has most often been considered is interpersonal communication and health education activities (76% of included reviews), particularly home visits and group approaches, and packages that include such activities. This includes a large number of high-confidence reviews. There are also a number of reviews of community mobilisation approaches, either as a single intervention or in a package.

For social media and m-health there is a large number of systematic reviews (n=12) relative to the availability of impact evaluations (n = 13). Many of these reviews have important methodological limitations; however, commissioning more systematic reviews in this area is unlikely to contribute much more to the knowledge base until new impact evaluations are available.

There are several 'synthesis gaps' – areas with clusters of impact evaluations but no high-quality systematic reviews.

These include:

- Demand-side financing;
- Group-based interpersonal approaches;
- Community mobilisation or community mobilisation packages for reproductive health;
- Community mobilisation or community mobilisation packages for water, sanitation and hygiene and infant feeding and nutrition;
- Demand-side financing, specifically conditional cash transfers and effects on child growth and development;
- And provider training and service delivery adjustments.

A significant proportion of the systematic reviews were assessed to have methodological limitations (72%). Common reasons for reviews being downgraded to medium or low confidence were: lack of independent screening and data extraction; lack of risk of bias assessment, or where an assessment was done, not reporting or analysing the findings separately by risk of bias status; or using simple counting of studies by the direction of effect or statistical significance to synthesise findings.

Figure 2
Adolescent sexual and reproductive health evidence gap map

- Impact evaluations
- High confidence
- Medium confidence
- Low confidence
- Protocol

Interventions

Societal and institutional			Community and interpersonal					Education systems			School- and community-based education		Financial incentives and savings programmes				Health systems				Outcomes			
on-Health and other ICT	Mass media	Policies and laws	Policy advocacy	Community mobilisation and dialogue	Family mobilisation and dialogue	Peer education and mentorship	Drama and music	Social groups and clubs	Teacher training	Hygiene and sanitation improvements in school	Health services and counselling in school	Sexual health education and other instruction at school	Concessions and other instruction outside of school	Sexual health education and other instruction at school	Cash transfer programmes	Income generation and savings programmes	Volunteers and subsidies	Community health workers and home visits	Community health distribution and supply chain improvements	Community health			Provider training and youth-friendly service adaptations	
										N/A												Knowledge and awareness	Adolescent knowledge, attitudes and empowerment	
																								Attitudes, self-efficacy and normative change
																							Sexual behaviour	Adolescent behaviours
										N/A													Contraception and other prevention	
																							Menstrual hygiene	
										N/A													Communication and support-seeking	Adolescent health
										N/A													Pregnancy and births	
										N/A													Abortion	
										N/A													HIV / STI testing and incidence	
																							Sexual and intimate partner violence	
																							Other health outcomes	
																							Accessing and utilising services	Health services
										N/A					N/A	N/A							Providers and service quality	
																							Education outcomes	Enabling environment
																							N/A	
	N/A									N/A	N/A												N/A	
N/A										N/A													Marital status	
										N/A	N/A	N/A											Parents and family	
N/A										N/A					N/A								Community and CBOs	
N/A		N/A			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Laws and policy	
																							Cost analysis	Cross cutting themes
																							Effects by sex	
																							Effects by marriage status	
																							Effects for very young adolescents	
																							Effects by rural or urban area	
																							Effects for other subgroups	

Health topics covered by the ASRH evidence gap map

- Family planning
- Healthy timing and spacing of pregnancy
- Abortion
- HIV and AIDS and other sexually transmitted infections
- Intimate partner violence and sexual violence
- Menstruation and feminine hygiene
- Voluntary medical male circumcision
- Female genital mutilation
- Rights, norms and empowerment associated with the above topics
- Factors that can affect sexual and reproductive health, such as education, economic development, livelihoods, empowerment, drug and alcohol use, or child marriage (only included if the authors clearly report sexual and reproductive health outcomes as primary or secondary outcomes of interest and provide effect sizes for those outcomes)



iStock.com/Milenny

Main findings – Adolescent sexual and reproductive health

The ASRH EGM includes 122 completed and 20 ongoing impact evaluations and 13 completed and 1 ongoing systematic review covering SBCE interventions (Figure 2). The box on page 5 outlines specific health topics.

Impact evaluations

Interventions providing sexual health education and other instruction within and outside of the classroom have the most amount of evidence. Many of the curricula tested come from an HIV prevention perspective rather than from the perspective of pregnancy delay and prevention, or other aspects of sexual and reproductive health. Evidence on programming around pregnancy prevention and family planning for both unmarried and married adolescents, including around the use of long-acting reversible contraception, is largely missing. Few studies evaluate interventions from health services and counselling in schools, or community health workers and home visits. There is little evidence on the effects of mass media, m-health, and other information and communication technology approaches.

The most common outcomes measured are those related to knowledge, awareness, attitudes and self-efficacy. Few studies measure effects on menstrual hygiene behaviours, abortion, or sexual and intimate partner violence. While many approaches target the family, community or peers, studies generally do not measure changes in norms, beliefs or behaviours of these actors. Few studies measure normative change related to gender, marriage and sexual activity. There is little evidence assessing provider and service quality.

Half of the impact evaluations are from just five countries: Kenya, Malawi, Mexico, South Africa and Uganda. Some critical areas with heavy investment in programming, such as francophone African countries, have very little evidence. Only two studies took place in a post-conflict environment; there is none from humanitarian or other crisis environments.

Research on how SBCE programming works is missing for a number of adolescent sub-populations. This includes adolescent boys; very young adolescents (ages 10–14); lesbian, gay, bisexual, transgender and questioning adolescents; and unmarried and married adolescents.

Most studies only provide limited disaggregation of results, for example by sex only, and do not provide further analysis.

The most commonly used study design was randomised controlled trials, but poor reporting and missing cost information limit the usefulness of the evidence base.

A wide range of reporting quality was noted. Studies often include inadequate descriptions around the context of the evaluation, the interventions and associated theories of change. The question of cost-effectiveness is notable in its absence from the included impact evaluations. This is a critical area of research that would improve policy decision-making about where to invest limited resources.

Systematic reviews

We identified a number of intervention areas with synthesis gaps. There were multiple impact evaluations assessing similar outcomes but little or no synthesis for cash transfer programmes for ASRH, family mobilisation and dialogue, or sex education in schools, or on instructional approaches specifically for very young adolescents aged 10–14.

Conclusions

Investing in SBCE interventions will be critical to achieving the Sustainable Development Goals and the objectives set out in the Every Woman Every Child Global Strategy, especially as the provision of clinical services is not enough to ensure actual access or uptake of services, nor realise the well-being of women, children and adolescents. The two EGMs summarised here provide a starting point for researchers, decision makers and programme managers to access the available research evidence on the effectiveness of SBCE interventions. While there is increasing evidence for SBCE interventions from which we can draw important learning and recommendations, we do need more and better research moving forward. We identified a number of limitations common across studies in this literature.

These findings should be considered in the design and reporting of future impact evaluations and systematic reviews to help to improve and advance research on SBCE interventions:

- Studies rarely report on outcomes related to the enabling environment, such as health provider attitudes and communication skills, household communication, social norms or levels of community participation;
- Analysis of how SBCE intervention effects vary by marginalised population groups is frequently missing;
- There is limited evaluation evidence available on m-health and other information and communication technologies;
- The usefulness of studies is often limited by inadequate reporting, including in descriptions of interventions, study design and the context of the evaluation;
- Few of the studies include qualitative components or process evaluation, and it is rare for studies to include information on cost or cost-effectiveness analysis;
- There are very few evaluations of interventions in francophone African countries; and
- A significant proportion of the included systematic reviews was assessed to have methodological limitations. These limitations include unclear inclusion criteria around intervention and health topic; no use of independent screening or data extraction; missing risk of bias assessment of included studies; and approaches that rely on simple counting of studies by direction of effects or statistical significance to synthesise findings.



About these maps

3ie produced two EGMs on which this brief is based:

- *Social, behavioural and community engagement interventions for reproductive, maternal, newborn and child health: an evidence gap map* and 3ie evidence gap map report (forthcoming) by Anayda Portela, Jennifer Stevenson, Rachael Hinton, Marianne Emler, Stergiani Tsoli and Birte Snilstveit. This report was conducted jointly by WHO and 3ie with funding support from the Partnership for Maternal, Newborn & Child Health, the Norwegian Agency for Development Cooperation and the United States Agency for International Development.
- *Adolescent sexual and reproductive health: an evidence gap map*, 3ie evidence gap map report 5, by Kristen Rankin, James Jarvis-Thiébaud, Nadine Pfeifer, Mark Engelbert, Julie Perng, Semi Yoon and Anna Heard. 3ie conducted this report with funding support from the William and Flora Hewlett Foundation.

WHO commissioned this brief through funding received by the Norwegian Agency for Development Cooperation.

While the EGMs were produced using the same methodology, several differences should be noted:

The focus of the original ASRH EGM was broader than SBCE interventions. As a result, the findings from five intervention categories, including those related to policy, law, physical improvements to schools, commodity distribution and supply chain improvements, and three outcome categories were excluded from this brief, which focuses exclusively on SBCE interventions. All other categories in the ASRH EGM fit the scope of SBCE.

The ASRH EGM included studies published from 1990 to 2016, while the RMNCH EGM included studies from 2000 to July 2016.

The ASRH EGM excluded low-confidence systematic reviews.

Some studies evaluate programmes that contain multiple components or multiple interventions within one evaluated programme. The research teams took different approaches to coding studies that evaluate this type of programming. The RMNCH project identified common packages of interventions and coded studies that included multiple SBCE interventions into the most relevant package. Conversely, the ASRH project coded a study of a multi-component programme in multiple intervention categories.



Jessica Lea/Department for International Development



The International Initiative for Impact Evaluation (3ie) is an international grant-making NGO promoting evidence-informed development policies and programmes. We are the global leader in funding, producing and synthesising high-quality evidence of what works, for whom, how, why and at what cost. We believe that using better and policy-relevant evidence helps to make development more effective and improve people's lives.

 3ieimpact.org

 [/3ieimpact](https://www.facebook.com/3ieimpact)

 [@3ieNews](https://twitter.com/@3ieNews)

 [/3ievideos](https://www.youtube.com/3ievideos)

 [international-initiative-for-impact-evaluation](https://www.linkedin.com/company/international-initiative-for-impact-evaluation)



World Health Organization



The Partnership for Maternal, Newborn & Child Health

October 2017