1 NO DEMAND CREATION, NO IMPACT

THE PROBLEM

Today's primary prevention and treatment strategies need new approaches to "demand creation". While there's innovation in this field, it's applied unevenly across interventions. Data gaps on the costs and cost-effectiveness of demand-side thinking are pervasive; the funding gap for primary prevention makes this necessary work seem like a luxury.

THE RISK

The perfect can become the enemy of the good. The risks in arguing for intentional and thoughtful introduction plans are that access gets slowed down in pursuit of an unattainable ideal and that expectations of the program design approach are overinflated.

THE PATH TO A SOLUTION

Understand not everyone can do demand creation. It's a science, not a set of slogans. This is true for treatment; it's the bedrock of primary prevention. Find the people who can do it, the programs that have done it before and work with them to do it consistently. Reaching the right people is more important than reaching all people. Limited resources should be allocated to tailored demand-side thinking.

The future of new and existing biomedical prevention options depends on investment in "demand creation", a term that has been around for a long time and is increasingly becoming a buzzword in discussions about HIV services. The problem with buzzwords is that they can mean everything and nothing. Demand creation encompasses many things, and always will. But there's a minimum set of pieces that should be considered, if not in place, and often isn't. We think the future depends on defining—and doing—demand creation right.

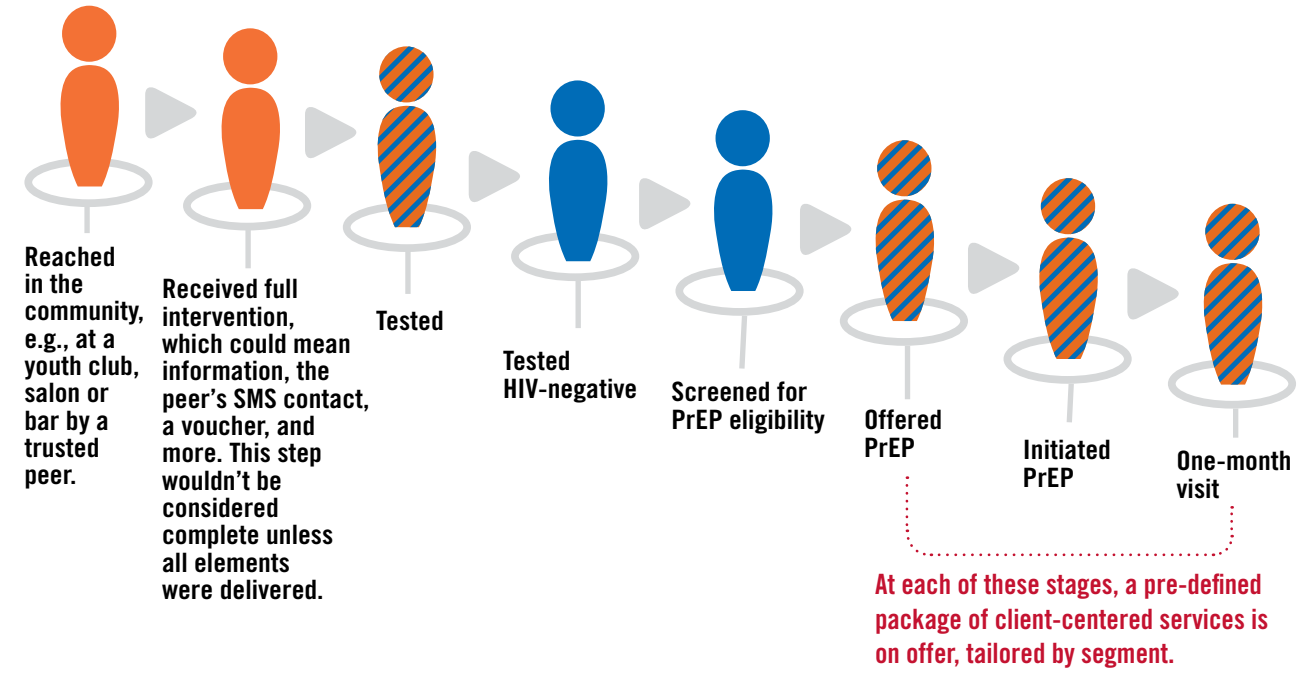
First, what is demand creation? Well, demand is what people do when they want something—at least some people, in some cultures. It's a capitalist-inflected word, to say the least, and it presumes that people can act freely which, in fact, they often can't because of laws, stigma, the threat of violence or discrimination. It's a phrase that can seem tone deaf to human rights abuses. Yet, it's also commonly used and so we're noting the issues and living with the lexicon in this section.

Demand is different from need. Lots of people who need things don't demand them. Adolescent girls don't see themselves as being at risk of HIV. Adult men living with HIV don't regularly take to the streets to get on ART and achieve virologic suppression. So demand creation could also be described as the science of awakening a sense of interest in the people who do need a given product. At its best the product itself reflects what people want. HIV prevention can't always do that, but it can still do a lot—as this section describes.

Finally, demand creation is the antidote to the "if you build it, they will come" approach that posits people will come for a service or strategy just because it's good for their health or their pocketbooks.

FIG. 3 Towards a Demand Creation Cascade

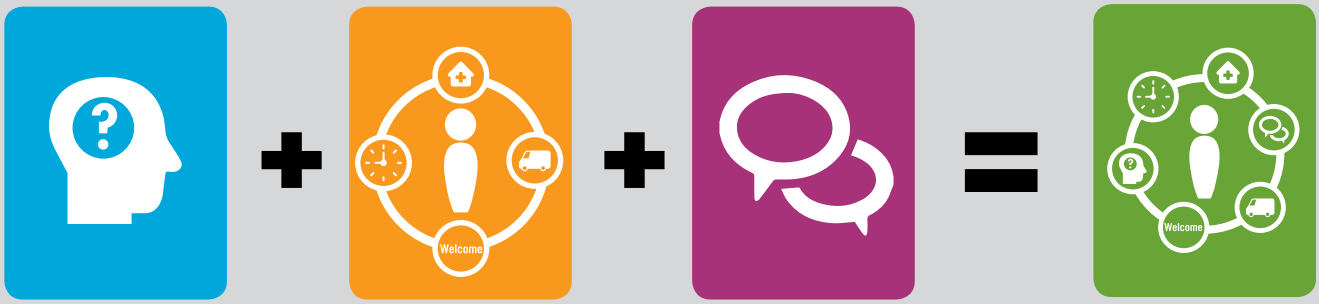
Many countries report low initiation and continuation of PrEP. This doesn't mean people don't want the product. They might not want the program that's offering it; or they might not be being reached. A "demand-creation cascade" such as the one proposed here for PrEP is one way to evaluate the program *and* the product. It would measure how many people received the full suite of demand-side activities the program hopes to deliver at a given stage. The precise set of steps would depend on the service-delivery design and strategy in question.



There are many groups working on different types of prevention cascades today—broadly and for specific interventions like PrEP. This cascade, developed by AVAC, builds off of that work.

Human-Centered Design: How it adds up

Human-centered programming is increasingly offered as a solution to public health challenges, but what does it really mean? This simple graphic shows some of the core elements in the equation.



Demand-side analysis + **User-centered service-delivery models** + **Engagement of people who will use the product, peers and counselors for HCD-informed interpersonal communication** = **Human-centered programs**

A brief history of demand creation and HIV

When the HIV response started in earnest in the late 1980s, fear was a primary motivator for many government-sponsored public health campaigns. By contrast, communities sought to create messages that emphasized self-protection and self-care and, in some cases, sexual pleasure in the context of a frightening new virus. Once antiretroviral drugs became available, messages shifted in places where people had access. If you had HIV, you should find out so that you could start care and, eventually treatment, and live.

There were many variations on these campaigns but they were often broad, public health-oriented efforts, aimed at reaching large swathes of people, regardless of their risk. For example, in the US, a law against referencing homosexuality in US-funded public information meant that national HIV messages didn't speak to gay men, transpeople or queers at all.

Demand creation today: Evolving thinking, unevenly applied

More than 30 years into the epidemic the era of one-size-fits-all public health campaigns is over, if it ever truly existed. At this year's International AIDS Conference in Amsterdam, plenary speaker Nduku Kilonzo said about Kenya's decision to develop a "Prevention Revolution Roadmap" to tailor packages to geographies and populations, "In 2014, we recognized that the 'spray and pray' one-size-fits-all approach applied generically for HIV interventions was not delivering on the required results for prevention."

One-size-fits-all doesn't work for treatment these days either. The current treatment guidelines recommend offer of ART to a person on the same day that he or she receives an HIV-positive diagnosis. The message to come for testing if you're sick so you can get better no longer applies to everyone. Many people are no longer on their deathbeds when they start ART. There's an increasing push for demand creation around ART and viral load access, so that people who achieve undetectable status are aware and can use that information as inspiration and reassurance. Men are a particular focus of this work; adolescents and young people are another.

The success of today's ART and primary prevention programs depends on demand

creation that is well-resourced and –conducted. Investments by the US government, the Bill & Melinda Gates Foundation (including work that AVAC is a part of, see pages 14-15), and other partners reflect this reality. But for a concept that's been around for a long time, the precise components of demand creation are awfully fuzzy. The first task for advocates is to get clear on what we're demanding in the first place.

Demand creation—or "demand-side" thinking, a phrase some practitioners prefer—involves the collection and analysis of high-quality information about the mindset of the potential client or user of a strategy. Human-centered design, a discipline within demand-side thinking, uses this information to identify different groups of users, or segments, and then maps their "journeys'" to product use. At first glance, demand-side thinking and human-centered design (see page 20 for expanded definitions) can look a lot like socio-behavioral research, which also tries to understand people and their preferences and beliefs through qualitative or hybrid qualitative-quantitative methods.

A recent paper by Betsy Tolley (reference in Fig 4) compared human-centered design and socio-behavioral research. Some of the key differences, as summarized in Figure 4, involve the speed with which the work is conducted, the design and use of research protocols, and the explicit application of private sector-derived concepts regarding markets, users, preferences and mindsets. Tolley, whose long history with SBR makes her something of an ideal informed skeptic about demand-side work writes, "During product introduction, the development and rapid testing of messages, materials, and

FIG. 4 Comparison of Traditional Socio-Behavioral Research and Human-Centered Design Approaches

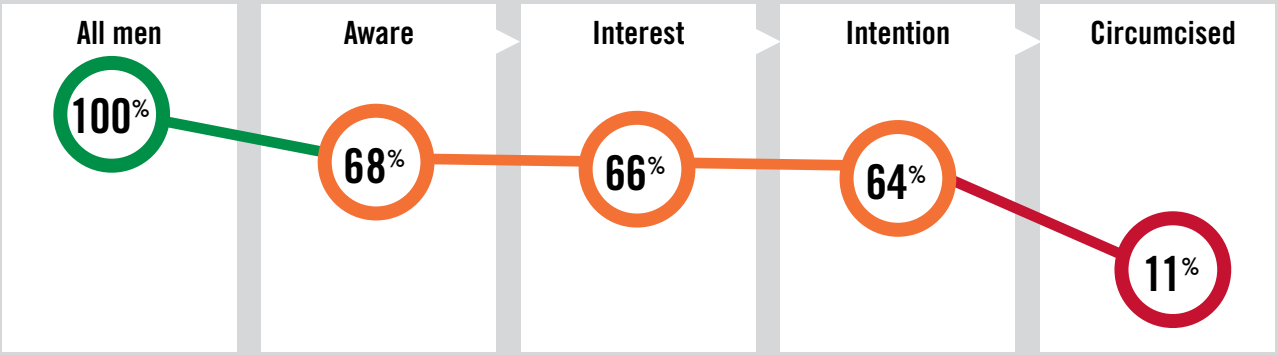
The table below comes from an article by Betsy Tolley, which contrasts human-centered design (HCD) with "traditional socio-behavioral research" (SBR). It resists over-simplification like: "HCD looks for solutions, SBR looks for theories", while also giving a sense of the differences between formal, protocol-driven SBR and a commerce– and private sector-derived methodology, now proving its worth in public health.

	TRADITIONAL QUALITATIVE SBR VS	HUMAN-CENTERED DESIGN RESEARCH
Overall objective	Generate information and theories about behaviors that could be used to inform design or intervention goals	Arrive at new solution-based immersive experience of end-user and context
Recruitment	Priority on defining participants, categories to ensure data saturation	Priority on identifying a wide range of experiences using rapid, flexible processes
Proximity to field	Immersion by researchers, often "behind the scenes", to reduce participants' "reactivity"	Immersion by multidiciplinary research team, allowing for immediate feedback
Data capture	Audio-recordings and verbatim transcriptions preferred	Field notes and rich media assets preferred
Synthesis of findings	Step-by-step "auditable" process, with emphasis on scientific rigor	Rapid and iterative review of data to generate creative insights
Outputs & dissemination	Text to convey the content with dissemination in peer-reviewed journals and other forms	Rich media collateral and a toolkit of assets that facilitate empathetic ideation

Source: FHI 360. Traditional Socio-Behavioral Research and Human-Centered Design. December 2017. Accessible at: *www.theimpt.org/documents/reports/Report-HCD-BSS-Research.pdf.*

FIG. 5 Using HCD to Solve a Problem, Part 1: Defining the problem

To understand low uptake of voluntary medical male circumcision (VMMC) in Zimbabwe, researchers surveyed nearly 2,000 men aged 15-29 in 2013 and realized there was a big gap between intention and action. A team in Zambia did similar work.



Using HCD to Solve a Problem, Part 2: Understanding the client

In Zambia and Zimbabwe, researchers identified multiple different "types", including champions, scared rejectors and more. They then prioritized a subset of categories for outreach based on the size of the segment, risk, potential for becoming advocates, and likelihood of uptake, such as the three listed below.

Enthusiasts

Large potential for uncircumcised men, high commitment, dissonance issues

Neophytes

Large potential, knowledge gaps, addressing knowledge gap is relatively easy

Embarrassed / Rejecters

Moderate potential, low commitment, embarrassed, afraid—need social support

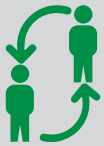
Using HCD to Solve a Problem, Part 3: Strategies derived from HCD research

Finally, the HCD research was used to guide specific messages for each target segment. Counselors received training and support on how to use simple questions to identify which type of man they were speaking to, and then tailored their approach, while communications campaigns provided broad messages based on men's feedback.

Segmentation

Honest communication about pain and procedure

Targeted messaging



Improve client experience

Advocacy (e.g., messages about sexual appeal)

Information on demand

These data come from research activities in Zambia and Zimbabwe funded by the Bill & Melinda Gates Foundation, implemented by IPSOS Healthcare and PSI. For a write up of findings, see Sgaier et al. eLife 2017;6:e25923. DOI: *https://doi.org/10.7554/eLife.25923.*

approaches aimed at increasing access to new products could benefit from an HCD lens."

VMMC, which has generated roughly a decade of demand creation activities fitting virtually all definitions, has recently yielded some much-discussed models (see Fig 5 on previous page).

The problem is that the lessons learned from VMMC and the dynamic discourse around HCD and demand-side thinking are not routinely applied. This is also the case when it comes to applying SBR to clinical research. Advocates don't need to know everything about these evolving terms, or to choose one approach over another, but we do need to understand that demanding thorough, well-designed demand creation early on in product introduction, or as soon as a problem has been identified, is essential for success in biomedical primary prevention. And that when we demand these things, we shouldn't necessarily take up the task of providing the answers.

Demand creation and advocacy: Necessary, not the same

Demand creation is not civil society advocacy. When civil society demands something—which it often does—that is neither an example nor the result of demand creation. In the earliest years of VMMC, AVAC—which did and does a great deal of advocacy around the need to scale up the policies and budgets needed to deliver VMMC—was often asked about getting more men to go for the procedure. At that time, we were solely working as advocates. There was expertise on staff in social marketing, but we saw our role as working in coalition to ensure action on guidelines and funding, including investments in good communications and demand creation.

Today AVAC actually does do work in the demand-creation space (see pages 14-15). We also work as advocates and are concerned by the reliance on underfunded civil society partners as the demand-creation team for new interventions, irrespective of whether these partners have experience with the critical components of demand creation.

This doesn't mean civil society can be excluded from demand-creation processes. Involvement is essential, not just as fous group participants but as experts on technical advisory groups. However, when a civil society group, coalition or constituency is tasked with primary responsibility for messaging or demand creation it should be a red flag. Far too often, civil society is asked to lead on things that program implementers don't want to or aren't able to spend real money on.

Cutting to the chase: Lessons on demand creation from VMMC

In the past few years, communicators, scientists, program staff and civil society stakeholders working on demand creation for VMMC have provided valuable examples of what these pieces look like in action.

With VMMC, the first five years of most countries' programs showed low levels of coverage. As Emmanuel Njeuhmeli, the USAID senior biomedical prevention advisor who oversaw the agency's work on VMMC for many years, has said of the early VMMC programs, "There was less focus at that time on creating demand for services as we were very cautious about not going against the local culture. Rather, the program just followed the natural demand that existed [...]."[3]

Importantly, this low level of initial demand never imperiled the program. It just impelled the search for better strategies. VMMC rolled out with strong support from the US government, so the budget was there, as were targets. Since VMMC reduces risk of HIV in males of all ages, the target was a percentage of all males within a specific age range. Many countries developed national plans, often with the assistance of grants from funders like the Bill & Melinda Gates

[3] Njeuhmeli, Emmanuel. *Nine Years Devoted to Voluntary Medical Male Circumcision for HIV Prevention: Reflections on an Unprecedented Public Health Intervention.* 2017. Accessible at: *https://blogs.plos.org/collections/vmmc-reflections/.*

Foundation and/or technical support from the World Health Organization. Some of these conditions are different from the ones that apply for PrEP today—as we discuss starting on page 18.

For VMMC, a jump in the numbers of men coming for the procedure coincided with the infusion of funds for demand creation that came starting around 2014. Lots of issues triggered the attention: the age range of males coming for the procedure, lackluster demand, underutilized capacity and more.

Whether there is precise cause and effect is a matter of debate among VMMC implementers. In that sluggish first half-decade, countries came around to championing the benefits of VMMC, developed political will and became more invested in the intervention. However, it is also the case that the investments in demand creation did help increase uptake and identify the challenges and opportunities for reaching men in the age bands where the procedure would have the most public health impact. This happened because funders and implementers decided that boosting demand for VMMC was a priority and were willing to invest in a range of research, including investigations of men's needs, desires and motivators. This willingness to explore the nuances of experience, without necessarily knowing what form the final demand-creation strategy will take is critical, and hard to do with rigid funding cycles and pre-set deliverables.

For VMMC, this work ultimately generated insights that helped improve uptake in target age bands in some cases, and to sustain programs in other places where early geographies and communities had reached saturation level.

Many insights focused on the "journey" that different types of men—grouped on the basis of formative research—go through to decide whether to undergo VMMC. The figures on page 11 show the outcomes of one example of this work.

VMMC has also yielded some of the only information about the cost of demand-creation activities in a programmatic setting. Surprisingly, these figures

Key Questions for Advocates to Ask About Demand Creation Plans

- Who is developing the demand creation approach, what is the methodology budget, timeline?
  - What is their expertise and do they have respect for and empathize with the people they are hoping to influence?
  - How are the views, needs and desires of the people using the product or service being solicited and incorporated?
  - How is the demand-creation work being iterated on during the life of the program and measured so that successes are built upon and failures captured so that they are not repeated?
  - Is there a comprehensive understanding of demand creation or do people just limit demand creation to mass media interventions?
- What are the relevant technical advisory groups within and outside of government that are linked up with the demand creation approach?
- How is the work connecting to other initiatives with relevant expertise?
- Do the group(s) leading the demand-creation work understand that not all civil society groups are made up of "end-users" of a given product; that civil society needs to be engaged not only in focus-group discussions but as architects of programs and engines of accountability?

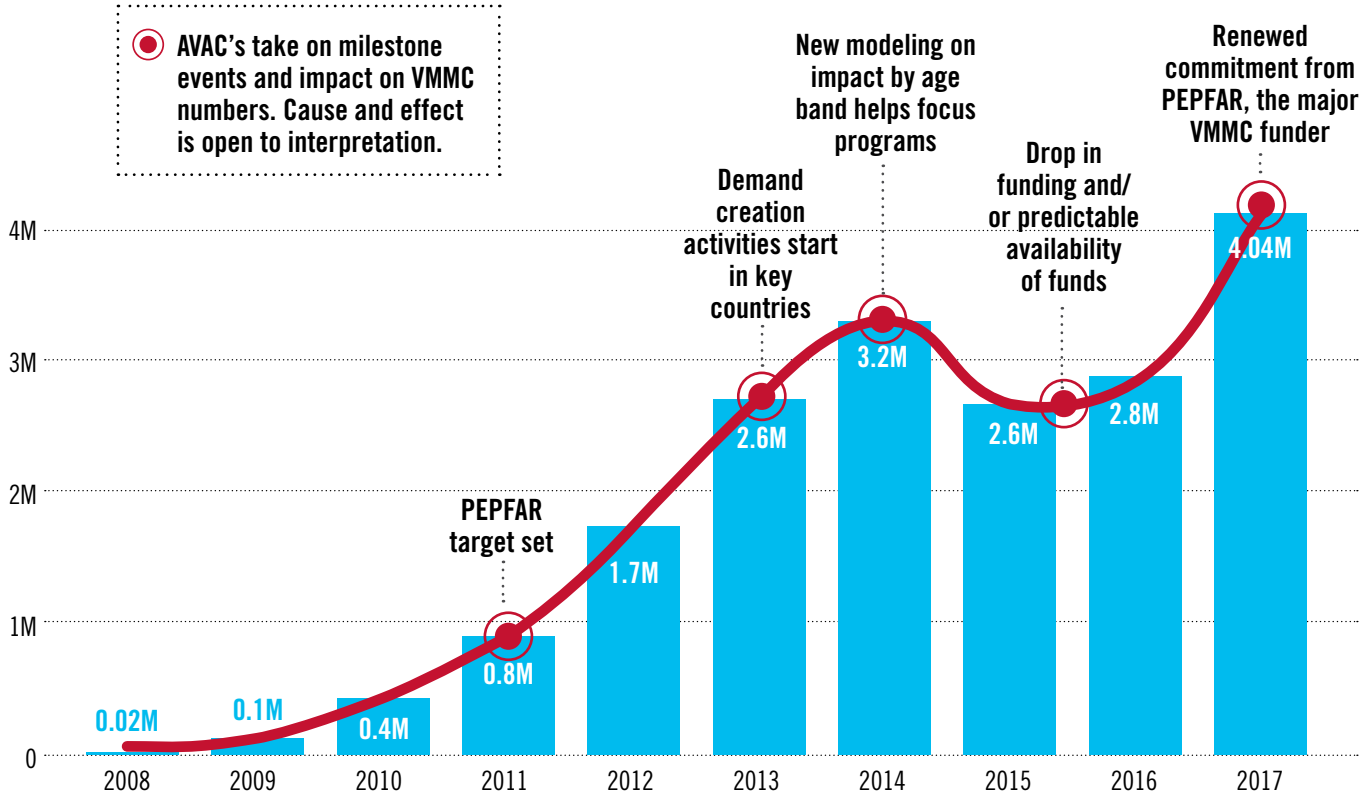
FIG. 6 Human-Centered Design: Part of AVAC's Expanded Work on Product Introduction

Over the past three years, AVAC has undertaken a new body of work focused on product introduction. This work complements the advocacy that remains central to our identity and mission. Across all our work, we seek to ensure timely availability and widespread coverage of efficient, effective and affordable HIV prevention options. Our product introduction work focuses specifcally on these four key areas: (1) Understanding the products' users, (2) Compiling and analyzing market data,

(3) Sharing information, (4) Bringing effective prevention options to those who need them. We are presently in the midst of a two-year collaborative research project called "Breaking the Cycle of Transmission", which is using human-centered design to improve approaches to delivering HIV prevention options amongst adolescent girls and young women. At the outset, AVAC and collaborators began by mapping out stages in the human-centered design process, which is new for many stakeholders. The table below is one output from this work—for more visit *https://www.avac.org/product-innovation-availability.*

Understanding and Increasing Impact:	BARRIERS & RISKS	HOW TO MITIGATE
Piloting		
M&E (intervention output)	**Measurement fails to capture behavioral change** The existing measures used to communicate ROI are often too focused on simple uptake measures to capture behavioral change. This and other meaningful HCD impacts can get lost in translation.	**Build a more robust picture of impact**
Scaling		
M&E (project impact)		
Communicate findings	**Deliverables aren't easy for outside audiences to pick up & understand**	**Tailor deliverables for specific audiences**
Broader dissemination		
Broader application	**Insights are shared, but aren't used to develop new designs** While much HCD research exists and is open to be shared, audiences may not know where to find it, and don't often have the resources, expertise or desire to use insights developed by other firms.	**Plan for and incentivize reusing insights**

FIG. 7 **Annual Number of Voluntary Medical Male Circumcisions, 2008-2017**



Source for VMMC figures: UNAIDS. *Miles to Go—Closing gaps, breaking barriers, righting injustices.* July 2018. Accessible at: *www.unaids.org/en/resources/documents/2018/global-aids-update.*

aren't calculated separately or included in estimates of cost-effectiveness and impact. A recent study from the South African CAPRISA team[4] shows how simple analysis and adjustment of demand-creation activities can be tied to changes in cost and impact on uptake.

From success to struggle: Condoms and demand creation

Demand creation investment also has to be preserved over the long haul. When it isn't, healthy programs falter. This is agonizingly apparent with condom programming, so much so that UNAIDS has identified a "condom crisis" within the prevention crisis it also highlighted.

When condoms were first introduced as HIV prevention—and were the only biomedical tool available—many countries and funders invested substantially in a robust condom marketplace that included free public brands, socially marketed subsidized condoms and private-sector choices.

The advertising and demand-creation campaigns for socially marketed brands were innovative and country-driven. At their peak, socially-marketed

[4] Gavin George, Michael Strauss, Elias Asfaw. The cost of demand creation activities and voluntary medical male circumcision targeting school-going adolescents in KwaZulu-Natal, South Africa. Published: June 20, 2017. *https://doi.org/10.1371/journal.pone.0179854.*

KEY DEMANDS FOR DEMAND CREATION: AN ADVOCATE'S CHECKLIST

☑ **Tailored approaches to different "segments" of a population, without leaving out community and context.** Messages about various prevention and treatment approaches need to be tailored to reach specific segments of the population—with a finer degree of specificity than ever before. It is not a matter of reaching adolescent girls or sex workers with PrEP but of finding those at highest risk within these populations. The interventions—which might include peer outreach, media campaigns and tailored counseling—that might persuade a man who does day labor and sleeps in a hostel with little privacy, to initiate ART the same day he receives an HIV-positive test result, might be different from what a professional man in an urban center would need. If there is too much tailoring the target group can get stigmatized, so information and access for others in the community is important too.

☑ **Costed and quantified approaches to primary prevention-focused peer navigators and lay cadres that are integrated with similar approaches in other programs.** 2018 may be the year of the low-paid "volunteer" or "peer" or "low-level cadre" health worker. These groups of workers are the key for just about everything: testing, linkage to care, adherence support, championing PrEP and much more. The number of terms used in this paragraph are just a handful of the many different categories thrown around by countries and implementing partners. At times it seems like the future of the HIV response depends on an unpaid workforce made up of people living with or at risk of the virus—and, except for the "unpaid" part, it does. Program design has to tackle the roles, compensation and standardized training and support for these cadres to create demand and support choices about primary prevention and ART.

☑ **Breakdown of costs for demand creation by prevention intervention and "yield" in national and implementer budgets.** At the 2018 regional planning meetings for PEPFAR programs, many countries committed to robust demand-creation programs focused on viral load and the individual and public health benefits of undetectable status, known commonly as U=U. But when it came down to checking whether there was enough money to make good on these commitments, the budget lines for demand creation and communication work often seemed inadequate. And that was just in the context of U=U. Scant resources for primary prevention can scare people off of looking at the costs of doing specific activities thoroughly and well, but that just makes for shoddy programs and less incentive to spend more. Putting demand-creation budget lines into programs and tracking that spending along with performance must be done by PEPFAR and national governments as well as programs.

Demand creation investment also has to be preserved over the long haul. When it isn't, healthy programs falter. This is agonizingly apparent with condom programming.

condom programs provided 20-25% of condoms and covered approximately 15-20% of total global need. Today, of the 32 major social-marketing programs, only a dozen remain—and that number is going down. In countries like Burkina Faso, the rollback of a social-marketing program coincided with an increase in new HIV diagnoses.[5]

Daily oral PrEP: The most demanding strategy to date?

To work, demand creation needs to be systematic and sustained, and reviewed for iterative improvements on an ongoing basis. It also needs to be situated in the larger context: it isn't a solution to societal or structural flaws. Nowhere is this more apparent than with daily oral PrEP.

Based on the most recent data presented at the International AIDS Conference, the largest and highest-risk population in need of PrEP—adolescent girls and young women—either isn't starting or isn't staying on daily oral PrEP. In one Kenyan study, less than half of all sex workers and MSM came back for their one-month visit after initiating PrEP. For adolescent girls and young women in the same study, the figure was less than a third. After six months, retention rates stood at 15% for MSM and 10% for AGYW.[6]

Kenya launched its program with intentional, audience-specific design, so the problem can't be traced solely to the approach to demand creation. Instead, one of the largest barriers to PrEP uptake may be that adolescent girls and young women have limited agency to choose to use the product and/or may not consider themselves at risk of HIV. In this instance, a major structural and societal issue—the gender inequities that drive the epidemic—are also hindering PrEP uptake.

Many people who need PrEP the most are the ones who can't or don't want to negotiate condom use, who don't know for sure that their partner living with HIV is monogamous and virologically suppressed, who have insecurity in housing, income or personal safety. In these contexts, it can be difficult to choose or consistently use any product—pill, injection or ring.

The critical step for oral PrEP programs now is to look at what's been learned, iterate the demand-creation activities accordingly and document the demand-creation cascade (see Fig 3, p. 8) to understand who's being reached with which components of a package designed to promote HIV prevention, with PrEP as one option. PEPFAR's DREAMS program for AGYW is making strides to documenting "layering"—the number of adolescent girls and young women reached with multiple interventions—and this work could inform routine measurement of demand cascades. That won't solve issues with young women's agency, but it will help the strategy, and other HIV prevention messages, reach incrementally more adolescent girls and young women than it has to date.

The information across multiple prevention and treatment strategies is clear: peers and lay counselors make a major difference in rates of uptake and retention. Perhaps more than any other prevention strategy, PrEP depends on strategic engagement and fair remuneration of frontline peers, "champions" or adherence supporters. These cadres are called different

[5] Condoms 2.0: Reinvigorating effective condom programming in the era of epidemic control. AIDS 2018. Accessible at: *http://programme.aids2018.org/Programme/Session/1475.*

[6] How long will they take it? Oral pre-exposure prophylaxis (PrEP) retention for female sex workers, men who have sex with men and young women in a demonstration project in Kenya. AIDS 2018. Accessible at: *http://programme.aids2018.org/Programme/Session/135.*

things in different places—community health workers, peer educators, etc.—but whatever the name, they need to be adequately compensated and integrated into demand-creation programs. There is substantial evidence showing that mass media, e.g., a billboard, is important to legitimize a product or raise awareness, but the interpersonal communication element is crucial in giving people the information they need.

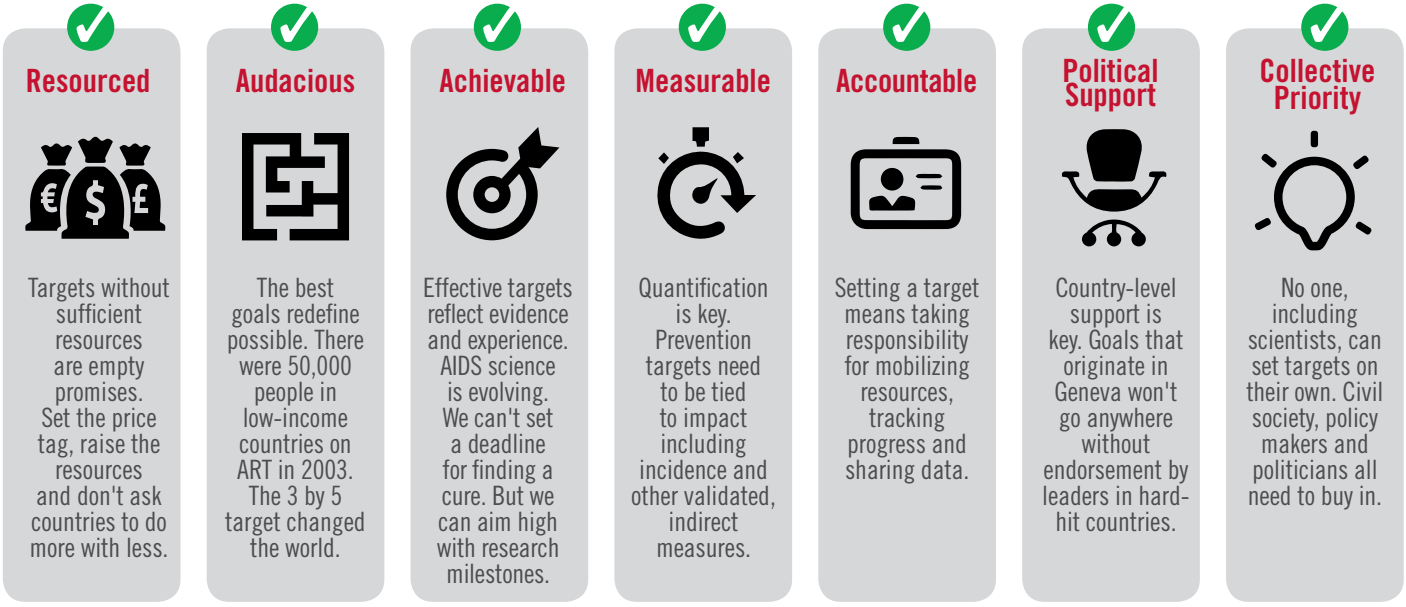
This work isn't a given and, in many places, it isn't happening. Save for Kenya, South Africa and Zimbabwe, there are few African countries with national plans inclusive of multi-year targets and overall program costs and demand-creation campaigns designed to reach people who need PrEP most. There are smaller efforts supported by specific PEPFAR implementing partners, but fewer national-level communications and demand-creation campaigns before PrEP hits the shelves in clinics. Uganda, for example, has had a PrEP program for nearly two years and has not yet released any communications materials.

The ideal approach would be for countries to prioritize thoughtful user-led and –embedded demand creation for daily oral PrEP from the outset, with funders attaching conditionality to PrEP dollars so that this is a need-to-have element, and countries holding implementers to account for investing in comprehensive programs, not just putting pills on shelves.

This will not only buoy programs and set them up for success, it will also help improve size estimates for those in need. A successful PrEP program for sex workers or men who have sex with men or adolescent girls and young women will be one that is welcoming, affirming and offers a range of services that are easy to get to or meet people where they are. It can serve as a way to bring identified key and vulnerable populations into contact with services and incentivize others to seek services. This is a virtuous cycle of information feeding programming, rather than the vicious one of no good estimates, no targets, no budget, no real program.

FIG. 8 Anatomy of a Target

It's been four years since AVAC advanced these criteria for effective targets in our 2014/15 Report, *Prevention on the Line*. Then, we identified targets that have advanced the field and ones that have fallen short. Today's prevention crisis exists in part because the primary prevention targets set by UNAIDS didn't meet these criteria. Targets for primary prevention are still essential, but they won't get met without demand creation work, such as we describe in this section. It's not too late to recalibrate resources and commitment.



NOT CREATED EQUAL: A LEXICON FOR PUBLIC HEALTH PROMOTION

ACTIVISM AND ADVOCACY

Activities by individuals or groups aimed at influencing decisions within political, economic and social institutions and systems. The distinction between activism and advocacy is often a matter of tactics—direct action, street protests and other forms of escalating disruption are associated with activism.

Advocacy is not demand creation. When civil society groups are asked to be partners in service delivery, such as by staffing drop-in centers or holding education events, they do so as experts. But their participation in this work does not mean that they cede their right to do advocacy and activism to hold funders, governments and program implementers accountable. With shrinking funding for civil society activism, many groups take on demand-creation work and can feel torn about challenging policies and programs tied to their funders. Groups are pulled into areas where they may or may not have the expertise—all PLHIV are not experts in human-centered design—and away from the areas where they and others have essential skills and leadership. Expanding the resource allocation for true accountability-focused advocacy and activism is key, as is ensuring that groups who do partner in demand-creation work can do critical watchdogging and advocacy without fear of lost funds.

DEMAND CREATION

The activities undertaken to raise awareness about a strategy and that, if successful, lead people who need the strategy to seek it out. These activities could include peer educators, information fairs, mass-media campaigns, radio programs, school, church or community-based outreach, one-off or recurring events and many other approaches.

Demand creation is not necessarily reflective of human-centered design. A demand-creation strategy can be and often is based on what's been done in the past, what's worked in the past (these are not the same thing), what fits within the project or program budget, or what's considered acceptable by political leaders, policy makers or implementers.

HUMAN-CENTERED DESIGN

A specific approach to designing demand-creation strategies, often undertaken with an emphasis on better defining difference within a group of people, such as men or adolescent girls and young women, who might be the desired users of a strategy. Its results are not guaranteed. It can yield actionable insights that boost uptake of products among key groups, but it can also be time-consuming, expensive and unforgiving of shortcuts.

SOCIO-BEHAVIORAL RESEARCH

Socio-behavioral research is a qualitative approach used to explore and describe human attitudes and behaviors and to generate theories that could be tied to design or intervention goals. Beyond addressing immediate intervention goals, however, SBR is about building the evidence base and contributing to new scientific knowledge. Its common features include a research protocol that is approved by ethics and/or institutional review boards and a theoretical framework guiding the work.