Demand Generation for Reproductive, Maternal, Newborn and Child Health Commodities

AN ADAPTABLE COMMUNICATION STRATEGY FOR CONTRACEPTIVE IMPLANTS

Contents

Acronyms

Application for Contraceptive Eligibility	ACE
Community Health Workers	CHWs
Demographic and Health Surveys	DHS
Every Woman Every Child	EWEC
Information and Communication Technologies	ICTs
Interpersonal Communication	IPC
Intrauterine Devices	IUDs
Long-acting Reversible Contraception	LARC
Millennium Development Goals	MDGs
Monitoring and Evaluation	M&E
Multiple Indicator Cluster Survey	MICS
Non-governmental Organizations	NGOs
Public Private Partnerships	PPPs
Public Service Announcement	PSA
Reproductive, Maternal, Newborn and Child Health	RMNCH
Short Message Service	SMS
Social and Behavior Change Communication	SBCC
United Nations	UN
United Nations Commission on Life Saving Commodities	UNCoLSC
World Health Organization	WHO

Introduction

Aim

To provide step-by-step guidance and illustrative content in creating a communication strategy to generate demand for **contraceptive implants**.

Intended User

This Adaptable Communication Strategy is designed to be useful to multiple audiences, including staff from ministries of health, non-governmental organizations (NGO) and community-based organizations. The Strategy can support the efforts of communication professionals working directly on behavior change communication programs as well as other professionals working in reproductive, maternal, newborn and child health (RMNCH) who need to create a demand generation component to support program activities.

What is a Communication Strategy?

A communication strategy provides a "road map" for local action targeted at behavior change and creates a consistent voice for the messages, materials, and activities developed. It also ensures that activities and products work together to achieve the program goal and objectives. The final communication strategy should be used to guide content development of program materials, such as advocacy briefs, client leaflets, and job aides and tools for health providers, thereby ensuring consistent positioning and messaging across all activities.

The communication strategy, however, is not a static product. It must be responsive to an ever-changing environment. Adaptations may be necessary in order to respond to new research findings and data, unexpected events, changing priorities, or unforeseen results. Communication strategies are essential in addressing priority or emergent health issues and allow for harmonization of priorities, approaches and messages among all the relevant organizations and stakeholders.

How to Use this Adaptable Communication Strategy

This Strategy forms part of a comprehensive *Demand Generation Implementation Kit for Underutilized Commodities in RMNCH* (http://sbccimplementationkits.org/demandrmnch). The Implementation Kit ("I-Kit") includes commodity-specific communication strategies designed to be easily adapted across multiple country contexts and integrated into existing RMNCH plans. The I-Kit also includes resources on three core cross-cutting demand generation areas: addressing the role of gender; utilizing information and communication technologies (ICTs) and new media; and leveraging public-private partnerships (PPPs).

This Strategy is not intended to serve as a "one-size-fits-all" model. It is designed as a quick-start foundation based on available evidence to provide guidance in answering the following questions:

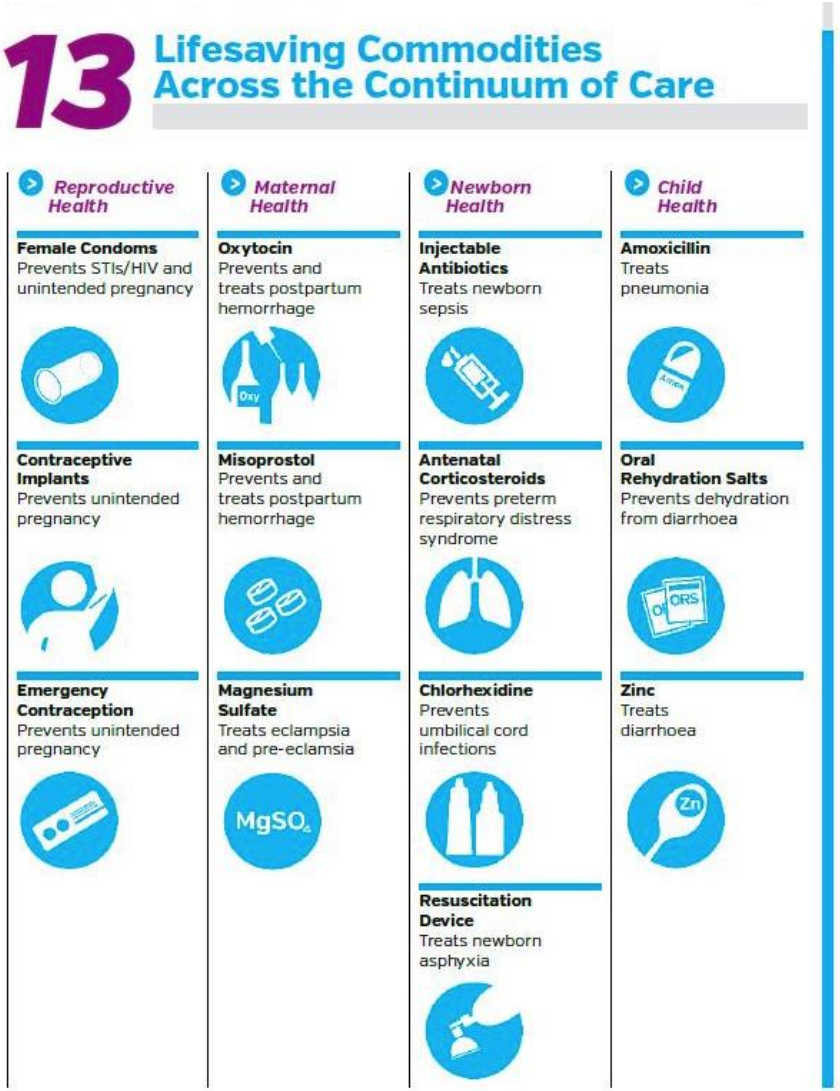
- Where are we now?
- What is our vision?
- How are we going to achieve our vision?
- How do we know we achieved our vision?

Ideally, country-level teams would then integrate commodity-specific content tailored to the country context into existing or new RMNCH communication strategies for demand generation.

It is important to note that the strategy focuses on communication – typically the product promotion component of a social marketing approach. If desired, the strategy can be integrated and expanded into a broader social marketing framework, addressing product, price and place.

Thirteen Life-Saving Commodities for Women and Children

In 2010, the United Nations (UN) Secretary-General's *Global Strategy for Women's and Children's Health* highlighted the impact that a lack of access to life-saving commodities has on the health of women and children around the world. The Strategy called on the global community to save 16 million lives by 2015 through increasing access to and appropriate use of essential medicines, medical devices and health supplies that effectively address leading avoidable causes of death during pregnancy, childbirth and childhood. Under the Every Woman, Every Child (EWEC) movement and in support of the Global Strategy and the Millennium Development Goals (MDGs) 4 and 5, the UN Commission on Life Saving Commodities (UNCoLSC) for Women and



Children's Health was formed in 2012 to catalyze and accelerate reduction in mortality rates of both women and children. The Commission identified 13 overlooked life-saving commodities across the RMNCH 'Continuum of Care' that, if more widely accessed and properly used, could save the lives of more than 6 million[1] women and children. For additional background information on the Commission please refer to: http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities

[1]For assumptions used to estimate lives saved see UNCoLSC Commissioner's Report Annex (http://www.everywomaneverychild.org/images/UN_Commission_Report_September_2012_Final.pdf)

Demand Generation: An Overview

What is Demand Generation?

Demand generation increases awareness of and demand for health products or services among a particular intended audience through social and behavior change communication (SBCC) and social marketing techniques. Demand generation can occur in three ways:

- Creating new users - convincing members of the intended audience to adopt new behaviors, products or services;
- Increasing demand among existing users - convincing current users to increase or sustain the practice of the promoted behavior and/or to increase or sustain the use of promoted products and services;
- Taking market share from competing behaviors (e.g. convincing caregivers to seek health care immediately, instead of not seeking care until their health situation has severely deteriorated or has been compromised) and products or services (e.g. convincing caregivers to use oral rehydration solution (ORS) and zinc instead of other anti-diarrhea medicines).

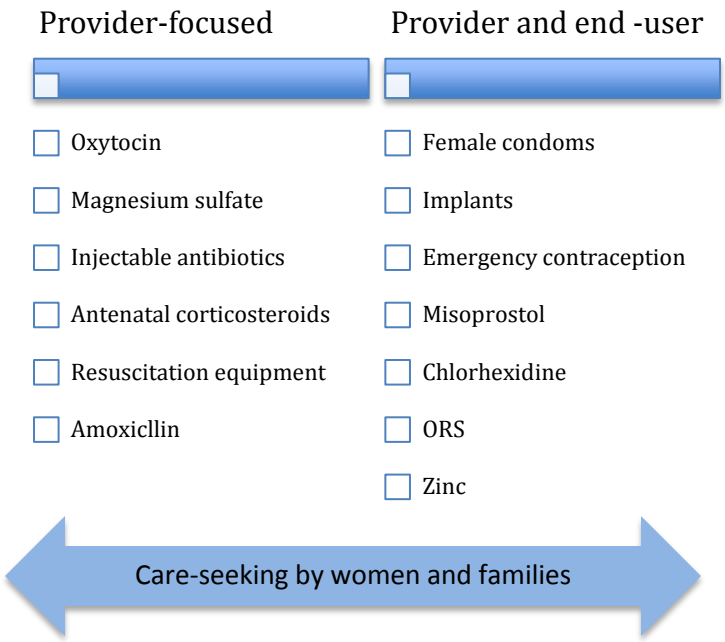
Demand generation programs, when well-designed and implemented, can help countries reach the goal of increased utilization of the commodities by:

- Creating informed and voluntary demand for health commodities and services;
- Helping health care providers and clients interact with each other in an effective manner;
- Shifting social and cultural norms that can influence individual and collective behavior related to commodity uptake; and/or
- Encouraging correct and appropriate use of commodities by individuals and service providers alike.

In order to be most effective, demand generation efforts should be matched with efforts to improve logistics and expand services, increase access to commodities, and train and equip providers in order to meet increased demand for products and/or services. Without these simultaneous improvements, the intended audience may become discouraged and demand could then decrease. Therefore, it is highly advised to coordinate and collaborate with appropriate partners when forming demand generation communication strategies and programs.

Who are the Audiences of Demand Generation Programs for the 13 Life Saving Commodities?

Reducing maternal and child morbidity and mortality through increased demand for and use of RMNCH commodities depends on the collaboration of households, communities, and societies, including mothers, fathers and other family members, community and facility-based health workers, leaders, and policy makers. Some of the commodities are more provider-focused in terms of demand and utilization, but all depend on care-seeking by women and families.



Key Concepts and Definitions in Demand Generation

Social and Behavior Change Communication (SBCC). SBCC promotes and facilitates behavior change and supports broader social change for the purpose of improving health outcomes. SBCC is guided by a comprehensive ecological theory that incorporates both individual level change and change at the family, community, environmental and structural levels. A strategic SBCC approach follows a systematic process to analyze a problem in order to define key barriers and motivators to change, and design and implement a comprehensive set of interventions to support and encourage positive behaviors. A communication strategy provides the guiding design for SBCC campaigns and interventions, ensuring

communication objectives are set, intended audiences are identified, and consistent messages are determined for all materials and activities.

Social Marketing. Social Marketing seeks to develop and integrate marketing concepts (product, price, place, and promotion) with other approaches to influence behaviors that benefit individuals and communities for the greater social good. (http://socialmarketing.blogs.com/r_craiig_lefebvres_social/2013/10/a-consensus-definition-of-social-marketing.html)

Channels and approaches:

Advocacy. Advocacy processes operate at the political, social, and individual levels and work to mobilize resources and political and social commitment for social and/or policy change. Advocacy aims to create an enabling environment to encourage equitable resource allocation and to remove barriers to policy implementation.

Community Mobilization. Community mobilization is a capacity-building process through which individuals, groups, or organizations design, conduct and evaluate activities on a participatory and sustained basis. Successful community mobilization works to solve problems at the community level by increasing the ability of communities to successfully identify and address its needs.

Entertainment Education. Entertainment education is a research-based communication process or strategy of deliberately designing and implementing entertaining educational programs that capture audience attention in order to increase knowledge about a social issue, create favorable attitudes, shift social norms, and change behavior.

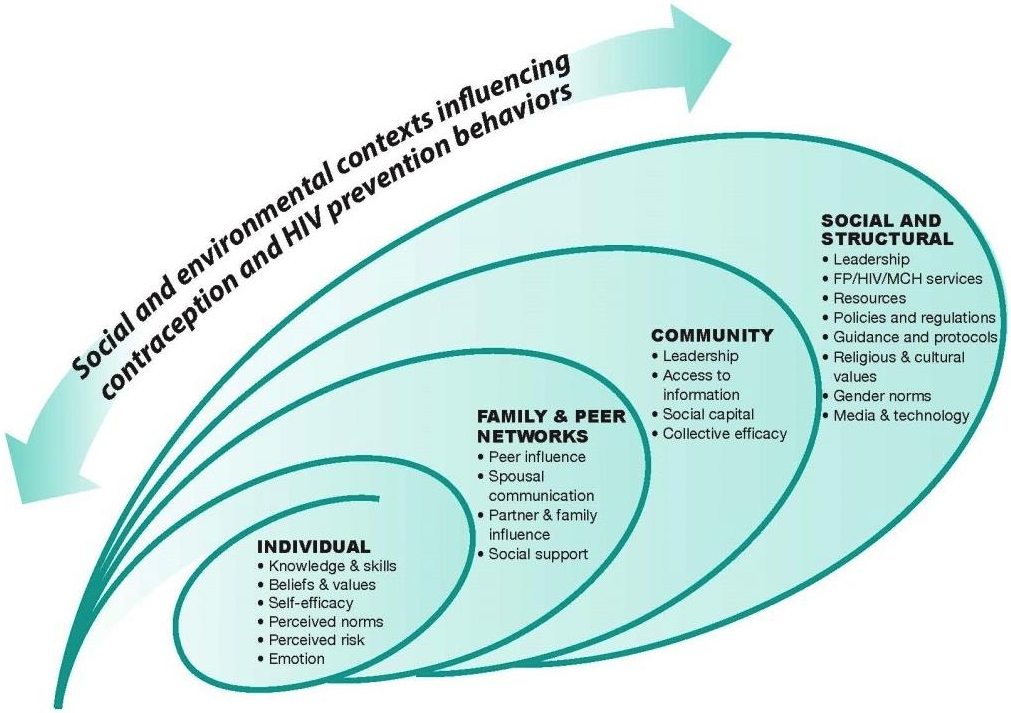
Information and Communication Technologies (ICTs). ICTs refer to electronic and digital technologies that enable communication and promote the interactive exchange of information. ICTs are a type of medium, which include mobile and smart phones, short message service (SMS), and social media such as Facebook and Twitter.

Interpersonal Communication (IPC). IPC is based on one-to-one communication, including, for example, parent-child communication, peer-to-peer communication, counselor-client communication or communication with a community or religious leader.

Mass and Traditional Media. Mass media reaches audiences through radio, television, and newspaper formats. Traditional media is usually implemented within community settings and includes drama, puppet shows, music and dance. Media campaigns that follow the principles of effective campaign design and are well executed can have a significant effect on health knowledge, beliefs, attitudes, and behaviors.

Conceptual Framework

This Strategy uses the social ecological framework to guide its strategic design. This model recognizes that behaviors related to demand for care and treatment take place within a complex web of social and cultural influences and views individuals as nested within a system of socio-cultural relationships—families, social networks, communities, nations—that are influenced by and have influence on their physical environments (Bronfenbrenner, 1979; Kincaid, 2007). Within this framework, individuals' decisions and behaviors relating to an increase in demand and utilization are understood to depend on their own characteristics as well as the social and environmental contexts within which they live. Applying this model in each stage of the communication strategy development helps to ensure that all determinants of behavior are considered and addressed.



Adaptable Communication Strategy: Structure and Guidance

This strategy presents a six-step process to guide country-level adaptation based on local situation analysis and formative research:

Explanations of each step are provided below. Illustrative content for each Step is provided in the following section.

Who Should Be Involved in Strategy Development?

Developing a communication strategy typically involves convening a group of stakeholders – ideally including representatives of the government, health area experts, marketing or communication specialists, and members of intended audiences – to review existing data, identify key audiences, and develop messaging and appropriate communication channels. Other potential partners may include private sector representatives for the formation of public-private partnerships, which can be used to strengthen a demand generation program, based on the needs and opportunities within an individual country context.

Step 1: Analyze the Situation

What is a situation analysis?

The situation analysis focuses on gaining a deeper understanding of the challenges and barriers to address within a specific context influencing the current demand and utilization of a priority RMNCH commodity, including those affected and their perceived needs; understanding social and cultural norms; potential constraints on and facilitators for individual and collective change; and media access and use by the intended audiences. It also examines the status of the life-saving commodity, including relevant policies, regulations, manufacturing, prices, supply-chains, availability, level of knowledge (provider and end-user), and level of use (provider and end-user). In short, the situation analysis answers the question, "Where are we now?"

Why conduct a situation analysis?

A comprehensive situation analysis is essential as it provides a detailed picture of the current state of the commodity, needs, and barriers which will direct the design and implementation decisions of the strategy and ultimately affect the level of success in generating demand and use.

How to conduct a situation analysis

As noted above, conducting a situation analysis typically involves convening a group of stakeholders and reviewing existing data in order to identify key information. A global synthesis of evidence conducted for each of the 13 under-utilized commodities can provide a global view of available information and lessons learned from other country contexts (Available at http://sbccimplementationkits.org/demandrmnch/evidence-synthesis*)*. Additional sources of country-specific secondary data may include Demographic and Health Surveys (DHS) (http://www.measuredhs.com/) or Multiple Indicator Cluster Surveys (MICS) (http://www.unicef.org/statistics/index_24302.html), quantitative and qualitative research conducted by NGOS, or private sector market research, where available, such as Neilson (http://www.nielsen.com/us/en.html). RMNCH policies and guidelines may also assist in analyzing the situation.

If existing data, particularly on social and behavioral drivers, is not sufficient, is outdated, or does not provide enough insight into priority audiences, it may be necessary to conduct additional primary formative research in the form of focus groups, interviews, or informal

visits to communities and homes. For all provider audiences, it may be especially important to conduct formative research around provider attitudes and other drivers to provider behavior.

What are the key questions?

The situation analysis has two main sections:

- Health and Commodity Context
- Audience and Communication Analysis

Health and Commodity Context

Below is an example of a set of questions to consider when analyzing the health and commodity-specific context relevant to contraceptive implants:

- *What is the contraceptive prevalence rate?*
- *What is the unmet need for contraception?*
- *What proportion of contraceptive users currently uses contraceptive implants? What proportion of contraceptive users currently uses hormonal methods? Long-term methods?*
- *Are contraceptive implants registered in country? What brands? If not registered, what is the registration process – time, requirements, etc.?*
- *What regulations or policies govern supply, distribution, and availability? How may these affect demand?*
- *What is the price of contraceptive implants in the private and public sector?*
- *What is the availability of contraceptive implants by region/district?*
- *What proportion of women, disaggregated by age and location (and other characteristics as relevant) currently use contraceptive implants?*
- *What is the estimated unmet need for contraceptive implants?*
- *What patterns exist in uptake of contraceptive implants over the past 5-10 years (increased, declined, remained static)?*
- *Number of private sector vs. public sector clinics offering implants by region/district?*
- *What level of provider (doctor, nurse, midwife, etc.) is permitted to insert/remove contraceptive implants?*

- *What is the price of the commodity in the private and public sectors? What are the costs of services associated with counselling, insertion and removal?*

Audience and Communication Analysis

Below is an example of a set of questions to consider when conducting audience and communication analysis:

Knowledge and attitudes

- *What proportion of providers, women, men and other audiences are aware of contraceptive implants?*
- *What proportion of providers, women, men and other audiences have accurate knowledge about contraceptive implants?*
- *What are the perceived benefits of using contraceptive implants by providers, women, their partners and other influencing audiences, such as mothers-in-law and community leaders?*
- *What are the perceived barriers to accessing and using contraceptive implants for providers, women, their partners and other influencing audiences, such as mothers-in-law and community leaders?*
- *Are there common misconceptions or misinformation about contraceptive implants?*

Normative and Structural Considerations

- *What are the gender norms in country among couples, both married and unmarried, and how do these affect contraceptive use?*
- *Under what circumstances is it acceptable to use contraceptive implants? Under what circumstances is it not acceptable?*
- *How does the level of income affect use of contraceptive implants? Do poorer women and couples have access to both information and product?*
- *Who are the stakeholders, key players, and gatekeepers who impact or influence demand and utilization of contraceptive implants?*
- *How are these stakeholders, key players, and gatekeepers influencing demand and utilization of contraceptive implants?*

Service Provision

- *What proportion of services for contraceptive implants is provided by the private sector and public sector? What are the perceived barriers and benefits to accessing services in each sector?*

- *Are protections in place in national counseling guidelines to ensure informed and voluntary decision-making related to contraceptive implants?*
- *Do counseling guidelines ensure adequate information on contraceptive implants, including side effects and use?*
- *Do providers have adequate skills to counsel, prescribe, and/or administer contraceptive implants?*
- *Are family planning (or maternal, newborn, child health services) services integrated with other services?*

Media and Communication

- *Do couples communicate about using contraceptive implants or similar commodities?*
- *Through what channels (including media and interpersonal) do providers, women, and their partners prefer to receive health-related information?*
- *What channels can support the level of communication needed to increase knowledge of PPH and demand for contraceptive implants?*
- *What communication materials and programs already exist related to contraceptive implants?*
- *What is the technical and organizational capacity of media partners?*

How to use the situation analysis

After conducting a situation analysis, program managers should be able to identify the key implications or challenges from the data. What are the reasons that contraceptive implants are not being utilized? What do potential users – end-user, health care providers, and health educators – believe about the commodity? Finally, select only a few key factors that the demand generation strategy will address. While it is tempting to address all factors, successful communication programs focus on the factors that will have the biggest impact given available resources.

It can be helpful to organize the collected information in order to distill the most important information, using a simple table organized by intended audience, such as the one below.

	Current Behaviors	**Primary Barriers to Desired Behavior**	**Primary Benefits of Desired Behavior**
End-user / community members (e.g. women, men, caregivers)			
Providers (incl. public and private, clinic- and community-based)			

In order to maintain an actionable focus throughout the strategy design, it is also helpful to synthesize the implications of this information. Population Services International Global Social Marketing Department offers the following series of questions to guide the development of a situation analysis and the selection of strategic priorities to be addressed by the demand generation strategy:

What?	**So What?**	**Now What?**
Data Collection: Key facts collected during the situation analysis	Data Analysis: Possible implications that the facts may have on the demand generation strategies	Strategic Priorities: Identify which implications to address in the demand generation strategy. Limit to 3-5 strategic priorities in order to focus the plan.
Example from Benin:		
Male partner support dramatically influences usage of family planning. In 2007, PSI data showed that only 34% of non- users of a family planning method discussed family planning with their male partner compared to 68% of current users.	To date, family planning interventions essentially targeted women and considered male partners as a secondary audience. Yet contraceptive prevalence rate remained very low, between 6% and 7%. A shift of focus is required.	Addressing men as a primary target group rather than just a secondary audience becomes a Strategic Priority.

Source: Population Services International. The DELTA Companion: Marketing Planning Made Easy.

(http://www.psi.org/sites/default/files/publication_files/DELTA%20Companion.pdf)

Step 2: Define a Vision

The vision anchors a communication strategy by stating what the program hopes to achieve. The vision should be agreed upon by the stakeholders involved in the strategy design process and will thus be "shared" by all. This shared vision is a short statement that articulates what is important; illustrates what is desired in the future; and guides the strategy design and development process. In addition, a true vision should be realistic, concrete, inspirational, provide direction, communicate enthusiasm, and foster commitment and dedication.

Some organizations call the vision the "Goal" or the "Primary Objective."

Step 3: Choose the Intended Audiences

Segment the Audiences

Segmentation is the process of identifying unique groups of people, within larger populations, which share similar interests and needs relative to the commodity. If the group shares common attributes, then the members are more likely to respond similarly to a given demand generation strategy. Segmenting allows for targeted use of limited resources to those populations that would most affect increased demand. It ensures that the activities developed and implemented are the most effective and appropriate for specific audiences and are focused on customized messages and materials.

While using the key findings collected from the situation analysis, the first step in audience segmentation answers the question, "Whose behavior must change in order to increase demand and appropriate use of the commodity?" Initial segmentation is often based on demographics, such as: age, sex, marital status, education level, socio-economic status, employment, and residence (urban/rural). Audiences can be further segmented by psychographics, which refer to people's personalities, values, attitudes, interests, and lifestyles.

Primary audiences are the key people to reach with messages. These may be the people who are directly affected and who would directly benefit from the use of the commodity. Or they may be the people who can make decisions on behalf of those who would

benefit from the commodity. Primary audiences may be further segmented into sub-audiences. For example, identifying specific segments of women of reproductive age who may share common attributes– such as young unmarried women, married women or high-parity women.

Influencing audiences are people who can impact or guide knowledge and behaviors of the primary audience, either directly or indirectly. Influencing audiences can include family members and people in the community, such as community leaders, but can also include people who shape social norms, influence policies, or affect how people think about the commodity. Prioritizing key influencing audiences by an estimated power of influence related to increasing demand and uptake of the commodity is crucial. For example, male partners are a likely key influencing audience, but the level of influence (low, moderate, strong) may depend on country context and/or commodity and should be discussed among stakeholders. In order to prioritize influencing audiences, a table like the one below can be helpful.

	Primary Audience Influenced	**Estimated Power of Influence (Low, Moderate, Strong)**	**Attitude Towards Use of Contraceptive Implants or similar commodities**
Influencing Audience 1			
Influencing Audience 2			

Primary or influencing audiences for demand generation may also include national, sub-national or community-level decision-makers, such as legislators and religious leaders, as they can be instrumental in removing or creating access barriers or spreading misguided beliefs about the product. Involving decision makers and influencers from the political and media realm and carefully considering the legal and policy environment are important to ensure demand generation efforts are not hindered by political or social barriers. *Scaling Up Lifesaving Commodities for Women, Children, and Newborns: An Advocacy Toolkit* (http://www.path.org/publications/detail.php?i=2381) provides advocacy resources to raise awareness and engage stakeholders in addressing commodity-related gaps in policy. Therefore, advocacy audiences are not included in this communication strategy.

Develop Audience Profiles

Audience profiles are the cornerstone of a communication strategy. Audience profiles first help bring to life and personify each audience segment, which subsequently guide communication messaging and activity planning. The profile should embody the characteristics of the specific audience, with a focus on telling the story of an imagined individual within the group who can neutrally represent the intended audience. Basing decisions on a representative, personalized example from a specific audience segment rather than a collection of statistics or a mass of anonymous people allows for more intimate knowledge of that audience segment and better defined and focused communication strategies. Therefore, the profile is important to ensure the messages are tailored to members of this selected group, resonate with them, and motivate them to take action.

Audience profiles for each audience segment are developed using the information collected in the situation analysis. The profile consists of a paragraph that should include details on current behaviors, motivation, emotions, values, and attitudes as well as socio-demographic information such as age, income level, religion, sex, and place of residence. The profile should exemplify the primary barriers to the desired behavior relative to the audience segment. The profile may include the name of this individual or a photo that represents this person to help visualize who this person is and tell his or her story. It is important to keep in mind that 1) no two audience profiles look the same as the same data will not always be available for each audience segment; 2) the best profiles use qualitative research as a source; and 3) profiles are to be living documents and regularly updated when new information becomes available. If the information gathered in the situation analysis lacks detail on a particular audience segment, additional research may need to be conducted to address the identified gaps. For example, for all provider audiences, it may be especially important to conduct formative research around provider attitudes and other drivers to provider behavior that could be used to better inform the audience profile and strategic design.

Step 4: Design Message Strategy (Objectives, positioning, key messages)

The message strategy is one of the most important elements of a communication strategy. It drives the rest of the program and ensures synergy, consistency and coordination for the purposes of shared objectives and clear, harmonized messaging among all stakeholders and partners. A message strategy is designed for each primary and influencing audience and includes (a) communication objectives, (b) positioning, and (c) key messages. As previously mentioned, audience profiles are used to determine whether or not the objectives, positioning and key messages are appropriate for that individual.

(a) Objectives

Communication objectives are measurable statements that clearly and concisely state what the target audience should know (think), what they should believe (feel), and what they should do (behave) as well as the timeframe required for the change. "SMART" objectives are Specific; Measurable; Attainable; Relevant; and Time-bound. Communication objectives should be derived from available evidence on the factors that drive or inhibit adoption by target users, as well as influencing audiences.

(b) Positioning

Positioning is the heart of the demand generation strategy and identifies the most compelling and unique benefit that the product offers the target audience. Positioning is often the emotional "hook" upon which the demand generation strategy hinges. Effective positioning moves beyond the functional benefits of the commodity and appeals to the target audience with emotional benefits.
Positioning presents the desired behavior in a way that is both persuasive and appealing to the target audience. It provides direction for developing a memorable identity, shapes the development of messages, and helps determine the communication channels to be used. Positioning ensures that messages have a consistent voice and that all planned activities reinforce each other for a cumulative effect.

As part of the positioning, a **key promise** is identified that highlights the main benefit associated with the proposed change. Changes in behavior, policies, and social norms are made only because there is a perceived benefit to those changes. The benefit must outweigh the personal cost of the change.

An accompanying **support statement**, also called a "reason to believe" in marketing, describes why the audience should believe the promise. This could be based on data, peer testimonials, a statement from a reliable source, or a demonstration. The key promise and support statement should include a balance of emotion and reason.

(c) Key Messages

Key Messages outline the core information that will be conveyed to audiences in all materials and activities. Messages cut across all channels, and must reinforce each other across these channels. When all approaches communicate iterative and harmonized key messages, effectiveness increases. Well-designed messages are specific to the audience of interest, and clearly reflect both a specific behavioral determinant and positioning. They also clearly describe the desired behavior, which must be "doable" for the audience. Key messages are not the text that appears in print materials (taglines), or the words that are used to define a campaign (slogans). Creative

professionals are often hired to translate key messages into a creative brief, which is a document for creative agencies or internal teams that guides the development of communication materials or media products, including taglines and slogans.

It is important that key messages are always:

- Developed on the basis of country-specific formative research;
- Derived from context-specific, strategic choices regarding segmentation, targeting, and positioning;
- Addressed to known drivers of and barriers to behavior change in the country context; and
- Pre-tested with the target audience and refined based on audience engagement.

Step 5: Determine Activities and Interventions

Activities and interventions allow for communication of key messages through a variety of communication approaches and channels. Messaging and media selection (i.e. channels) is best considered and selected in concert in order to effectively transmit information to the intended audiences. Activities should be carefully selected based upon type of messaging, ability to reach the intended audience through a variety of media/channels, timeline, cost, and available resources. It is helpful to refer to findings from the situation analysis to guide selection of activities and interventions. "*A Theory-Based Framework for Media Selection in Demand Generation Programs*" (http://sbccimplementationkits.org/demandrmnch/media-selection) is a helpful guide to inform media selection decisions based on communications theory. Table 1 is an overview of the types of strategic approaches that can be used. Any demand generation program should include activities across a range of different intervention areas and communication channels, which communicate mutually reinforcing messages.

It is also important to consider linkages with other new or existing programs and systems, both directly related to demand and those less closely connected but that have an impact on demand or could be utilized to improve efficiency. The following are examples of potential areas for linkages when designing a demand generation program for contraceptive implants:

- Other family planning programs that do not currently include contraceptive implants as part of the method mix
- Quality of care improvement initiatives for service providers/clinics
- Pre-service education and existing continuing education or in-service refresher training initiatives for clinical and non-clinical providers

- Supply chain management and market shaping
- Private sector approaches (For a guide to PPPs in demand generation, see the "P for Partnership" tool (available at http://sbccimplementationkits.org/demandrmnch/public-private-partnerships) and in supply chain management see the "Private Sector Engagement Toolkit [available at http://www.everywomaneverychild.org/images/content/life-saving-commodities/Private_sector_engagement_A_%20toolkit_for_Supply_Chains_in_the_Modern_Context.pdf]
- Non-family planning programs such as immunization, antenatal/postnatal care etc. (e.g. to provide counseling, disseminate materials) – at both the clinic and community levels
- Cross-sectoral programs (e.g. education, economic empowerment, transport)

Table 1: Overview of Strategic Approaches that can be used in Demand Generation

Advocacy: *Advocacy operates at the political, social, and individual levels and works to mobilize resources and political and social commitment for social change and/or policy change. Advocacy aims to create an enabling environment at any level, including the community level (i.e. traditional government or local religious endorsement), to ask for greater resources, encourage allocating resources equitably, and to remove barriers to policy implementation. "Scaling Up Lifesaving Commodities for Women, Children, and Newborns: An Advocacy Toolkit" provides advocacy resources for utilizing the Commission platform to raise awareness and engage stakeholders in addressing commodity-related gaps in policy. See: http://www.path.org/publications/detail.php?i=2381*
Community-Based Media: *Community-based media reach communities through locally-established outlets. Such outlets include local radio stations and community newsletters/newspapers as well as activities such as rallies, public meetings, folk dramas, and sporting events.*
Community Mobilization: *Community mobilization is a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their lives, either on their own initiative or stimulated by others. A successful community mobilization effort not only works to solve problems but also aims to increase the capacity of a community to successfully identify and address its own needs. For guidance on community mobilization see Howard-Grabman, L. & Snetro, G. (2003) How to Mobilize Communities for Health and Social Change, available at http://www.jhuccp.org/resource_center/publications/field_guides_tools/how-mobilize-communities-health-and-social-change-20.*
Counseling: *Counseling is based on one-to-one communication and is often done with a trusted and influential communicator such as a counselor, teacher, or health provider. Counseling tools or job aids are usually also produced to help clients and counselors improve their interactions, with service providers trained to use the tools and aids.*
Distance Learning: *Distance learning provides a learning platform that does not require attendance at a specific location. Rather, the students access the course content either through a radio or via the internet and interact with their teacher and fellow classmates through letters, telephone calls, SMS texts, chat rooms or internet sites. Distance learning courses can focus on training communication specialists, community mobilizers, health educators, and service providers. Additional information on eLearning can be found at Global Health eLearning Center and PEPFAR eLearning Initiative.*

Information and Communication Technologies (ICTs): *ICTs are fast growing and evolving platforms for electronic, digital technologies, including computing and telecommunications technologies, which enable communication and promote the interactive exchange of information. ICTs also include mobile and smart phones and the use of SMS, and social media such as Facebook, Twitter, Linked In, blogs, e-Forums, and chat rooms. This approach also includes web sites, e-mails, listservs, eLearning, eToolkits, and message boards. Digital media can disseminate tailored messages to the intended audience on a large scale while also receiving audience feedback and encouraging real-time conversations, combining mass communication and interpersonal interaction. A " Theory-Based Framework for Media Selection in Demand Generation Programs" (http://sbccimplementationkits.org/demandrmnch/media-selection) and "Utilizing ICT in Demand Generation for Reproductive, Maternal, Newborn and Child Health: Three Case Studies and Recommendations for Future Programming" (http://sbccimplementationkits.org/demandrmnch/ict-case-studies) are useful resources for program managers looking to utilize ICT in demand generation activities.*

Interpersonal Communication (IPC)/Peer Communication: *Interpersonal and peer communication are based on one-to-one communication. This could be peer-to-peer communication or communication with a community health worker (CHW), community leader or religious leader.*

Mass Media: *Mass media can reach large audiences cost-effectively through the formats of radio, television, and newspapers. According to a review of mass media campaigns, mass media campaigns that follow the principles of effective campaign design and are well executed can have small to moderate effect size not only on health knowledge, beliefs, and attitudes, but on behaviors as well (Noar, 2006). Given the potential to reach thousands of people, a small to moderate effect size will have a greater impact on public health than would an approach that has a large effect size but only reaches a small number of people.*

Social Mobilization: *Social Mobilization brings relevant sectors such as organizations, policy makers, networks, and communities together to raise awareness, empower individuals and groups for action, and work towards creating an enabling environment and effecting positive behavior and/or social change.*

Support Media/Mid-Media: *Mid-media's reach is less than that of mass media and includes posters, brochures, and billboards.*

Step 6: Plan for Monitoring and Evaluation (M&E)

M&E is a critical piece of any program activity because it provides data on the program's progress towards achieving set goals and objectives.

Although planning for M&E should be included in the communication strategy, avoid developing a complete monitoring plan at the time of strategy development (indicators, sample, tools, who will monitor, frequency of data collection, etc.). At the time of strategy development, focus on the indicators that should be incorporated into the program's plan. M&E indicators should be developed based

on formative research and should indicate whether the key messages and strategies are having the desired effect on the target audience.

A full M&E plan should then be developed as a separate program document. Developing an M&E plan should outline what M&E indicators to track, how and when data will be collected, and what will happen to the data once it has been analyzed. A variety of data sources can be used to collect M&E data. It is important to assess the scope and context of the program to choose the most applicable methodology, as M&E activities vary in cost, staff, and technology requirements. While some lower-cost M&E options will allow for identification of trends in demand for services, they may not be able to provide additional insight into the causal effects of activities and the way in which the program worked. To measure cause and effect, larger program-specific data collection activities geared towards evaluation are needed. See Table 2 below for examples of low and high cost options.

While the collection of M&E data tends to receive the most attention, it is also critical to have a process for analysis and review of the collected data. M&E data should be used to inform program changes and new program development. It is best to build these M&E review processes into existing program management activities to allow for regular dissemination of M&E indicators.

Table 2: Examples of low and high cost options of M&E for demand generation

Low cost option: A low cost option makes use of existing data sources and opportunities to gain insight into the program and its associations with changes in demand or uptake. However, it will only allow for the identification of trends and will not allow for the attribution of change to a given program or to program activities.

Illustrative data sources for a low cost option include:

- Service statistics (Information from clinics and providers such as referral cards and attendance sheets)
- Communication channel statistics (Information from television or radio stations on listenership of mass media activities)
- Omnibus surveys (Addition of questions related to program exposure and impact to omnibus surveys)
- Provider self reported data (Small scale surveys among providers about services rendered)
- Qualitative data (Focus group discussions, in-depth interviews)
- Demographic and Health surveys (Trends in contraceptive prevalence and method mix- approximately every five years)

High cost option: A high cost option makes use of representative program-specific surveys and other data collection methods to gain considerable insight into the effects of the program and the way in which it worked.

Illustrative data sources for a high cost option include:

- Service statistics (Information from clinics and providers such as referral cards and attendance sheets)

- Communication channel statistics (Information from television or radio stations on listenership of mass media activities)
- Provider self-reported data (Surveys among providers about services rendered)
- Large, nationally representative program-specific surveys (Focus on issues related to knowledge, perceptions, acceptability and use)
- Qualitative data (Focus group discussions, in-depth interviews, photonarrative, observation visits)
- Client exit interviews (Exit interviews will assess user satisfaction with services delivered including their perceptions, experience and intentions)

Indicators

M&E indicators should include process, output, outcome and impact indicators:

Process Indicators	Program Output Indicators	Behavioral Outcome Indicators	Health Impact Indicators
Measure the extent to which demand creation activities were implemented as planned	Measure a) changes in audiences' opportunity, ability and motivation to use implants, and b) the extent to which these changes correlate with program exposure	Measure a) changes in audiences' behavior, and b) the extent to which these changes correlate with program exposure	Measure changes in health outcomes

Key issues to consider when developing indicators include:

<u>Disaggregation</u>

To increase the utility of M&E data, indicators should be disaggregated to facilitate more in-depth analysis of program performance. It is recommended that indicators are, at minimum, disaggregated by:

- *Gender*. Disaggregating M&E data by gender can illustrate the different impact of programs on men and women, such as attitudes towards acceptability of the commodity.

- *Age*. At minimum, programs should be able to report data separately for beneficiaries aged 15-19; 20-24; and 25-49. Based on audience segmentation at country level, programs may wish to disaggregate the 25-49 age group further, in order to determine the extent to which interventions are reaching those for whom they were designed.

Other factors for disaggregation may include geographic location, marital status etc.

Bias

Common biases that programmers should be aware of when designing, implementing and interpreting M&E include:

- *Self-selection bias* – for example, a current family planning user may be more interested and willing to answer a survey about family planning compared to someone who does not approve of it or who has never tried family planning before.
- *Social desirability bias* – following exposure to health promotion initiatives, intended audiences may feel pressured to give 'right answers' to survey questions, e.g. to report positive attitudes towards a commodity even though they do not really feel that way. As demand generation interventions are successful at shaping positive social norms, social desirability bias may become more of a challenge in M&E.

An Illustrative Communication Strategy for Contraceptive Implants

Step 1: Analyze the Situation

Refer to page 13 for supporting guidance on this step as well as "Step 1" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/fp-step1) for further resources.

Health and Commodity Context

The majority of the information in this section is a global-level analysis for purposes of illustration. The country-specific situation analysis should be focused on the local context.

Health Context

Women of reproductive age in developing countries have an increased risk of unintended pregnancy. Each year there are an estimated 75-79 million unintended pregnancies worldwide, 46 million of which end in induced abortion, and about 20 million of which are considered unsafe abortions in non-medical settings (Singh et. al., 2009). There is an estimated 215 million women with an unmet need for contraception (Guttmacher Institute, 2008). Although globally contraceptive use has steadily increased in the past three decades, use in some of the poorest areas of the world, such as sub-Saharan Africa, remains low. It is estimated that less than one-fifth of couples in sub-Saharan Africa are using contraception (UN, 2011). There is global consensus that contraception has direct and indirect influences on a number of health outcomes including maternal, neonatal and infant health and community health (Kerber, 2007; Ronsman & Graham, 2007).

Globally, it is also recognized that expanding method choice leads to higher levels of contraceptive use. When women and couples can access a wide range of family planning methods, they are more likely to find a method they like and can use over a period of time, to switch methods when life circumstances change, and to meet their contraceptive intentions. Even among those who currently use contraception, many who would like to have no more children have no access to long-acting and permanent methods. Also, for women who live far from health services or who are not able to visit health clinics easily, long acting reversible contraception (LARC), including implants and intrauterine devices (IUDs), may be a preferred and more convenient option. Youth, in particular, must overcome significant barriers to access contraception that meets their needs and vulnerability to unprotected sex.

Although increased use of contraceptive implants could substantially reduce the numbers of unintended pregnancies, abortions, and maternal deaths, worldwide use of implants is low. Among married women between the ages of 15 and 49 around the globe, 53 percent use a modern method of contraception but less than one percent use implants.

Commodity Context

Hormonal implants consist of small, thin, flexible plastic rods, each about the size of a matchstick, which release a progestin hormone into the body. They are safe, highly effective, and quickly reversible long-acting progestin-only contraceptives that require little attention after insertion. Clients are satisfied with them because they are convenient to use, long-lasting, and highly effective. Implants, which are inserted under the skin of a woman's upper arm, prevent pregnancy for an extended period after a single administration. No regular action by the user and no routine clinical follow-up are required.

Implants are available from three main manufacturers - Bayer Pharma AG (Germany), Merck/MSD Inc (USA), and Shanghai Dahua Pharmaceuticals Co., Ltd (China) - with a cost ranging from $8.00 to $18.00 per unit. Two are currently prequalified by the World Health Organization (WHO). The most common types include:

- **Jadelle** (WHO prequalified): two rods each containing 75 mg of levonorgestrel, effective for five years, with recent price-reduction agreement with donor volume guarantees;
- **Sino-implant** (II)(not yet pre-qualified by WHO and is currently marketed under various trade names including Zarin, Femplant and Trust): two rods each containing 75 mg of levonorgestrel, effective for at least four years;
- **Implanon** (WHO prequalified) and **Nexplanon**: both with one rod containing 68 mg of etonogestrel, effective for three years. Nexplanon is radio-opaque, allowing x-ray detection if the rod is difficult to locate due to deep insertion, and also has an improved trocar. Recent price-reduction agreement reached with donor volume guarantees

Norplant (six rods each containing 36 mg of levonorgestrel, effective for five to seven years) was discontinued in 2008.

Implants are included in the WHO Essential Medicines list (2011) and specified as the two-rod levonorgestrel-releasing implant, each rod containing 75 mg of levonorgestrel (150 mg total). One rod implants are still not included in the WHO list. In addition, service delivery

policies and protocols, are in place in many countries, which support implant provision, including both two-rod and one-rod presentations. Given the different implant products that are available in diverse markets, technical requirements for competent training in counseling, insertion and removal of each product as well as related procurement processes is required to ensure that these commodities are provided appropriately. In some settings, policies allow task-shifting, which permit lower cadres of health care providers (i.e. providers other than doctors such as nurses or midwives) to insert and/or remove implants.

Jadelle is prequalified by the World Health Organization and distributed commercially by Bayer Pharma. Implanon is prequalified by the World Health Organization and is distributed commercially by Merck/MSD. Sino-implant (II) is not prequalified yet by the World Health Organization. It is marketed under a variety of names by different distributors in countries where it is registered: as Zarin by Pharm Access Africa, Ltd., as TRUST by DKT Ethiopia, and as Femplant by Marie Stopes International.

Given the up-front cost of implants, their high level of effectiveness and their longer duration of use, both public and private sector financing strategies are used. In the public sector, subsidies are provided to clients who are unable to pay, either through lower prices to users or through alternative financing arrangements such as vouchers. In the private sector, users in the higher wealth segments usually pay full price for this product, or modest subsidies are provided through public-private partnerships such as franchises or social marketing schemes.

Implants are safe for use by most women, including lactating mothers, women living with HIV, women who smoke cigarettes, women over the age of 35, women who have just had an abortion, women with diabetes, women at risk for cardiovascular disease (including those with high blood pressure), and adolescents. Women on antiretroviral therapy should discuss the use of implants with their doctor as the possibility of an interaction exists which might lead to somewhat reduced implant effectiveness. Implants can be initiated immediately after childbirth if a woman is not breastfeeding, and six weeks postpartum if a woman is partially or fully breastfeeding.

Stock-outs of contraceptive commodities and other needed equipment, instruments, and supplies for family planning provision are commonly reported in service programs. The unavailability of either the method or other needed instruments and supplies means that implants services are also unavailable. Thus, attention to logistics is critical, and must include instruments, expendable medical supplies as well as the contraceptive implant itself. One challenge for supply-chain management is that implants are often combined in information systems and on procurement lists.

(Source: Quoted from *Key Findings: Contraceptive Commodities for Women's Health,* 2012).

Audience and Communication Analysis

A recent global synthesis of existing demand creation evidence for implants found 15 peer-reviewed articles, grey literature and reports from 2003-2013 that specifically examined demand generation for contraceptive implants. The evidence was documented primarily from countries in sub-Saharan Africa (Health Communication Capacity Collaborative, 2013).

The literature identified three key determinants of implant demand and utilization:

Knowledge, especially of benefits: The long duration of implants effectiveness emerged as the most common perceived advantage of implants. Additional benefits identified included the ability to use when breastfeeding, comfort, and ease of insertion and removal (The RESPOND Project, 2010; 2012; Hubacher et al., 2011). Implants were also found to overcome a significant barrier among women in Ethiopia seeking family planning services but hesitant to expose their bodies because it does not require pelvic examination (Pathfinder-Ethiopia, 2008).

Fear of side effects: Fear of side effects was a common barrier across different country contexts. In Ethiopia, married women in urban areas cited concern about side effects as a reason for not long-acting methods, including implants and IUDs (Alemayehu, Belachew & Tilahun, 2012). In Nigeria, sexually active adolescent students did not use long-acting methods (including implants, IUDs and injectables) because they believed it could interrupt pregnancy or cause infertility and because of fear of side effects and religious and cultural barriers (Eke & Alabi-Isama, 2011). Fear of side effects was also found in Bangladesh, especially concerning changes in menstrual patterns (The RESPOND Project, 2012). In Tanzania, research shows concerns about painful insertion and fear it could cause cancer and weight loss or weight gain were also prevalent (The RESPOND Project, 2010).

Provider knowledge and bias: Although there was little evidence of social and behavioral drivers among providers, a study in Bangladesh found private providers had a low level of knowledge of method-specific side effects and poor perception of IUDs and implants as having too many or too adverse side effects (SHOPS/Abt Associates, 2012). Knowledge was also lacking on policy-related issues, such as who is allowed to provide long-acting methods. A high percentage of those surveyed claimed they felt competent to insert an implant, and many

were doing so, but had never received training. The study also found that although women cited their husbands were generally supportive of long-acting reversible methods, the majority of providers believed that husbands were opposed and that women should not use them without their husbands' support. For women attending public clinics in Zambia, barriers to using long-acting methods appeared to be more focused on provider barriers, such as lack of skilled providers, provider bias and commodity supply issues, as well as individual lack of knowledge (Neukom et al., 2011).

Example of Table to Organize Key Information

	Current Behaviors	**Primary Barriers to Desired Behavior**	**Primary Benefits of Desired Behavior**
End-user/community members (e.g. women, men, caregivers)	Each year there are an estimated 75-79 million unintended pregnancies worldwide, 46 million of which end in induced abortion, and about 20 million of which are considered unsafe abortions in non-medical settings Among married women between the ages of 15 and 49 around the globe, 53 percent use a modern method of contraception but less than one percent use implants	Very limited contraceptive options in developing countries for women and couples Limited awareness and promotion Fear of side effects including: Interrupt pregnancy, Cause infertility, Change menstrual patterns, Cause cancer or weight loss/gain	Long duration of effectiveness Can use when breastfeeding, comfort, ease of insertion and removal Does not require pelvic examination
Providers (incl. public and private, clinic- and community-based)	Low levels of promotion and insertion/use of contraceptive implants	Low levels of knowledge of method-specific side effects Poor perception of IUDs Low numbers of providers trained on inserting contraceptive implants	Method easily incorporated into current FP counseling Insertion of contraceptive implants is quick and easy Long-lasting – do not have to give on a monthly basis

Step 2: Define a Vision

Refer to page 18 for supporting guidance on this step as well as "Step 2" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/fp-step2) for further resources.

ILLUSTRATIVE VISION
Women, their partners, and their providers recognize implants as an affordable, safe, convenient and socially acceptable method to ensure healthy timing and spacing of pregnancies, leading to increased uptake of implants.

Step 3: Choose the Intended Audiences

Refer to page 18 for supporting guidance on this step as well as "Step 3" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/fp-step3) for further resources.

Primary and Secondary Audience Segments (with Rationale for segment selection)

PRIMARY AUDIENCES

Primary audience 1: Women of reproductive age (with sub-audiences, e.g. by life-stage - age, parity and/or marital status)

- **Sub-audience 1a: Young unmarried woman, pre-childbearing**– Many young women today are delaying marriage and family in order to further their education and/or career. Because many of these women are sexually active and do not want children until later in their lives, increasing their access to long-acting family planning options, such as implants, can support their reproductive and life choices and reduce unintended pregnancies.
- **Sub-audience 1b: Married woman, pre-childbearing**– Just as unmarried women are delaying marriage and family for education and/or career, married women are also waiting to start a family in order to save money and be financially prepared for the costs of raising a child. Increasing access to family planning methods, including implants, reduces unintended pregnancies and allows couples to plan to start their families when they are best suited to provide for a child's overall wellbeing.
- **Sub-audience 1c: Married woman who wants to space her births** – Increasing access to family planning methods, such as implants, promotes healthy birth spacing and continued family planning which allows the couple to prepare for a growing family if they choose to have another child. The positive effects of birth spacing are numerous and span the entire RMNCH spectrum by not only influencing the health of the mother and baby but also impacting the health and well-being of the entire family.
- **Sub-audience 1d: Woman who has completed her family** – Long-acting family planning methods, such as implants, are a good option for women who want no more children but may not be ready for permanent methods.

Primary audience 2: Clinical providers (public and private) - Clinical provider bias and lack of knowledge on implants and other family planning options similar to implants, has been identified as one of the larger barriers to increase uptake of this commodity, therefore making it extremely important to address these barriers at the provider level.

Primary audience 3: Non-clinical providers such as community health workers (public and private)- The non-clinical provider is the frontline worker based at the community level, often in the same community in which he/she lives. This cadre of provider can hold a variety of titles such as Community Health Worker or Community Health Volunteer. Just as clinical provider knowledge on all family planning options including implants is crucial, the non-clinical provider is just as important as they are the link connecting the community with health services at health facilities.

INFLUENCING AUDIENCES

Influencing audience 1: Male partners of women of reproductive age- Male partners can have significant influence, positive and negative, on their female partners when it comes to accessing, choosing and implementing family planning methods.

Influencing audience 2: Extended family members and community members- Family members, friends and community members can all influence a couple's or a woman's choice of using contraception (including type of contraception) for family planning. Where there is lack of knowledge within a community around a certain health topic like implants, myths tend to fill that void and create fear within the community, thus negatively influencing uptake and demand.

Audience Profiles

PRIMARY AUDIENCE 1: WOMEN OF REPRODUCTIVE AGE

Sub-audience 1a: Young unmarried woman, pre-childbearing

Ada, 19, Abuja, Nigeria.

Ada is unmarried and does not have any children yet. She lives with her mother and two younger siblings. She works in the market during the mornings, helping her mother prepare breakfast for people going to work. She earns enough money to pay for her cell phone, and she is saving money to finish school. Her dream is to become a teacher. Ada has friends from her neighborhood and they socialize sitting outside their houses. They talk about contraceptive options when the CHW comes to give monthly injectable contraception in their neighborhood, but they have not heard of implants. She has recently met a man who has a good job and he visits her in the evenings. She hopes to eventually marry and have a family. She sees herself as someone who can go far with hard work and determination. She is not ready to begin a family just yet.

Sub-audience 1b: Married woman, pre-childbearing

Vibha, 21, Lucknow, Uttar Pradesh, India.

Vibha is newly married and her mother-in-law is pressuring her every day to start having sons. She lives with her husband's parents and sister in a small house on the outskirts of Lucknow. She and her husband have talked several times about waiting to have children as they are hoping that he will soon have a new job with a better income. They feel they should save first before starting a family because education is expensive, and they want to buy a moto. She and her husband want a contraceptive option that is discreet and reversible, so that when they do want children, they will be able to have them right away. Vibha seeks health advice at a private clinic, as the wait at the public clinic is too long. Vibha is responsible for cleaning and cooking for her husband and his family, and she is beginning to make new friends with the young wives in her neighborhood.

Sub-audience 1c: Married woman who wants to space her births

Nana, 24, Mbale, Uganda.

Nana and her husband have one young son, 8 months old, and they want to wait for a while before their next child. She and her husband are both working – she is sewing clothes and he is a driver for a foreign company. Her mother and sisters help with childcare when she is working. Nana and her husband are active in their church and they have a large circle of friends and family with whom they often socialize. Nana is proud that she and her husband can afford the basic necessities for themselves and their child, but she always worries that they should be saving more as the economy is not good and she worries that an emergency will drain their family resources. They want to give their children a good education and they are saving to improve their roof. Currently they use the free condoms from the health sector, because Nana simply does not have time to go to the clinic and wait for an injection each month. Nana and her husband would like to be sure they are ready for each new child, so they want to wait before having another child.

Sub-audience 1d: Woman who has completed her family

Doma, 34, Tanga, Tanzania.

Doma has four children and she is proud that they are all healthy, strong and going to school. She does not want any more children as she has the sole responsibility of their care and well-being. Her husband works in the port in Dar es Salaam and comes home once a month. Doma is a good cook and she started a small roadside stand where she prepares lunch for workers. She is earning enough money to pay for her phone, cooking gas for her home, and school fees for her children. She and her husband want the best for their children and feel any more children would challenge their ability to provide for them. She has sexual relations only when her husband is home and he does not want to use condoms. It is hard to remember to take the pill each day and planning ahead for an injection is difficult, as she does not always know when her husband will come home. Doma wants an effective method that she does not have to think about.

PRIMARY AUDIENCE 2: CLINICAL PROVIDERS

Sara, a nurse working in a primary care facility in Kaduna, Nigeria.

Sara is proud of her education, what she has accomplished in life and the position she holds at the health facility. Even the young doctors sometimes will ask her advice on counseling young mothers. Sara's pride shows in her dedication to her work and to the people she serves. At times, this pride fosters a belief that she knows more than her clients and therefore knows what is best for them. Sara may not spend as much time as she could in really talking with her clients, getting to know them, and counseling them in a way that provides them with the information they need to make the choices best for them. She justifies her limited counseling time because of the number of patients she must attend to in one day. She has been providing family planning methods to married couples for many years and has her favorite methods that she often suggests over others she does not know as much about. For example, she is not confident in her abilities to insert the implant so does not mention implants much as a family planning option. She is not sure if implants are a good idea for young women who have not had a baby. Sara is open, however, to learning more about other family planning methods, even those that require clinical skills, if given in-service training.

PRIMARY AUDIENCE 3: NON-CLINICAL PROVIDERS

Susan, a community health worker in the peri-urban neighborhoods of Kampala, Uganda.

Susan is the often the first person who women in her area approach with questions about family planning. Susan develops strong peer-to- peer relationships built on trust and mutual understanding. Because of these strong relationships, she is able to communicate openly with her peers and community. Susan is proud of being a resource in the community and being looked upon as someone with a lot of knowledge on health issues. She was trained by a local NGO to talk about family planning methods three years ago, so her job aids are well-worn. Because she does not provide clinical services, she has more time to sit with members of the community and give them information on and referral for contraceptives. Susan distributes oral contraceptives and condoms, if she has the supplies. However, she is a member of the community that she serves, and she shares many of the same attitudes, social norms and beliefs of her community. Susan's beliefs can sometimes get in the way of providing appropriate unbiased information, especially about less common family planning products. She is open to learning more about family planning methods and gaining more skills, given the opportunity.

INFLUENCING AUDIENCE 1: MALE PARTNERS

Joseph, 28, married father of two in Tanzania.

Joseph works in construction when he can and his income is often just enough to cover the basics his family needs. He feels that as the provider for the family, it is his responsibility to make decisions regarding family planning. From what he has heard from friends,, he thinks family planning – especially a long-acting method- could help him and his wife delay their next child so they can save money to pay for education for their children. Joseph would like to talk to his wife but does not know how to start the discussion and is afraid talking about it would lead to an argument or them both feeling too embarrassed. He also worries that family planning methods may not be safe, or that using family planning methods could damage his wife's ability to get pregnant, or even cause sickness in future children. While Joseph may have difficulty expressing it, he does want the best for his wife and the children they already have or hope to have together.

INFLUENCING AUDIENCE 2: EXTENDED FAMILY MEMBERS & COMMUNITY MEMBERS

Elira, 52, mother-in-law in Elbasan, Albania.

Elira is very proud that her son is married with two children, and has a job to provide for his family. Her daughter-in-law is respectful and is good at keeping the home, and they get along well. Elira knows that today's families are often not as large as when she was a young mother, but she raised four healthy children and provided for them well, so now each day at meals, she is asking her son and daughter-in-law when they will have more children. Her son told her that they will wait for more children and his wife is considering using implants. Elira does not know about this method and she worries that it will affect her daughter-in-law's ability to have more children. Elira listens to the radio and speaks to her friends at the market each morning, and they share stories about their families.

Mr. Asena, 45, active community member in Uganda.

Mr. Asena owns multiple shops in a rural Ugandan town and is active in his community as well as in the church. He is quite vocal and enjoys discussing his thoughts with community members including topics around family planning even though he is not very knowledgeable in this area. His presence and influence in the community are shaping men's perceptions on family planning and choice in a negative and restricting way.

Step 4: Design Message Strategy

Refer to page 20 for supporting guidance on this step as well as "Step 4" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/fp-step4) for further resources.

PRIMARY AUDIENCE 1: WOMEN OF REPRODUCTIVE AGE

OBJECTIVES

By 2015, increase the percentage of women (15-49), at all levels of parity and marital status, who:

1) Recognize implants as a comfortable, healthy, affordable, and safe method of family planning for all kinds of women, including young women
2) Know where to access quality counseling and services for implants
3) Understand potential side effects of implants and feel confident to manage them or seek support from a health worker
4) Talk to their partner about fertility and family planning, including implants
5) Talk to friends and family about implants
6) Choose implants as a family planning method

POSITIONING

Freedom is a central positioning for implants for all segments of women. Implants can be positioned as liberating women in a variety of ways, sensitive to the country context:

- Freedom from worry about getting pregnant because of the high reliability of this method
- Freedom from thinking about family planning for 3-5 years due to the long effectiveness of this method
- Freedom from need to return to a facility to restock as implants only require a one-time action every 3-5 years
- Freedom from having a pelvic exam as this is not required to provide implants
- Freedom to change one's mind and expect immediate return to fertility upon removal
- Freedom to pursue life goals. Older women who use implants may be identified as "wise", while younger women may be identified as "savvy" women who are planning for their future.
- Freedom to be spontaneous in sexual relations as implants require no interruption of sexual activity.

PRIMARY AUDIENCE 1: WOMEN OF REPRODUCTIVE AGE

Other key positioning possibilities are:

Implants are ***flexible*** - they meet women where they are at all different stages of their life. They are an excellent choice for all kinds of women in all stages of parity. Young women (including adolescents) and those with no children can use implants to delay first birth but still preserve their fertility; low parity women can use to space the birth of their next child; implants are one of the few good options available to breastfeeding women; women who are living with HIV can use implants; women who just had an abortion can use implants; and, implants are good for women thinking about or deciding to limit births, with the option to remove if they change their minds.

Implants may also be positioned as ***affordable***, depending on the country context and whether they are available free of charge or at cost, or whether cost is considered a key barrier to family planning use. Implants are a one-time cost which, when spread out over the 3-5 year effective period, makes them an extremely cheap option compared to short-acting methods.

KEY PROMISE

If you choose to use the implant, you can safely and affordably avoid unintended and mistimed pregnancies, allowing you to achieve key goals for yourself and your family.

SUPPORT STATEMENT

Implants are a highly effective method of family planning that are long acting, reversible, and convenient to use.

KEY MESSAGES

Key messages for implants should focus on the benefits. Key information should also be provided in a simple, easy-to-understand and non-threatening way, including information about real side effects.

In line with the “Freedom” positioning, key messages for women of child-bearing age, segmented by life-cycle, may include:

Young unmarried woman, pre-childbearing:

- Talk to your friends about implants, the safe, easy, affordable method that gives you the freedom to be you (Knowledge: benefits).

PRIMARY AUDIENCE 1: WOMEN OF REPRODUCTIVE AGE

- Ask your provider about implants, the safe, easy, affordable method that gives you the freedom to plan your life (Knowledge: benefits; Provider bias).
- Implants are a safe method of family planning, including for young pre-childbearing women. Talk to your provider about how to manage possible side effects (Fear of side effects).
- Choose implants, and give yourself the time to achieve your dreams (Knowledge of benefits: long-acting).
- Choose implants; once it is inserted, you don't have to think about family planning and can be spontaneous (Knowledge of benefits: ease).
- Choose implants; they offer at least three years of protection against unintended pregnancy for a one-time insertion fee (Knowledge of benefits: affordability).
- Implants are quickly reversible and do not affect return to fertility (Knowledge: benefits)

Married woman, pre-childbearing:

- Talk to your partner about implants, the safe, easy, affordable method that gives you the freedom to plan your life together (Partner communication).
- Ask your provider about implants, the safe, easy, affordable method that gives you the freedom to plan your life (Knowledge: benefits).
- Implants are a safe method of family planning. Talk to your provider about how to manage possible side effects (Fear of side effects).
- Choose implants, and give yourself the time to build your life as a couple (Knowledge of benefits: long-acting).
- Choose implants; once it is inserted, you don't have to think about family planning and can be spontaneous (Knowledge of benefits: ease).
- Choose implants; they offer at least three years of protection against unintended pregnancy for a one-time insertion fee (Knowledge of benefits: affordability).
- Implants are quickly reversible and do not affect return to fertility (Knowledge: benefits)

Woman who wants to space her births:

- Talk to your partner about implants, the safe, easy, affordable method that gives you the freedom to focus on your family (Partner communication).
- Ask your provider about implants, the safe, easy, affordable method that gives you the freedom to focus on your family (Knowledge: benefits; Provider bias).
- Implants are a safe method of family planning. Talk to your provider about how to manage possible side effects (Fear of side effects).
- Choose implants, and give yourself the time to focus on your family (Knowledge of benefits: long-acting).
- Choose implants; once it is inserted, you don't have to think about family planning and can focus on what's important to you

PRIMARY AUDIENCE 1: WOMEN OF REPRODUCTIVE AGE

(Knowledge of benefits: ease).
- Choose implants; they offer at least three years of protection against unintended pregnancy for a one-time insertion fee (Knowledge of benefits: affordability).
- Implants are quickly reversible and do not affect return to fertility (Knowledge: benefits)
- Implants: a safe family planning method for breastfeeding women (Knowledge: benefits)

Woman who has completed her family:
- Talk to your partner about implants, the safe, easy, affordable, long-lasting method that ensures the completion of your family. (Knowledge: benefits).
- Ask your provider about implants, the safe, easy, affordable method that gives you the freedom to complete your family (Knowledge: benefits).
- Implants are a safe method of family planning. Talk to your provider about how to manage possible side effects (Fear of side effects).
- Choose implants, and give yourself the time to focus on your family (Knowledge of benefits: long-acting).
- Choose implants; once it is inserted, you don't have to think about family planning and can focus on what's important to you (Knowledge of benefits: ease).
- Choose implants; they offer at least three years of protection against unintended pregnancy for a one-time insertion fee (Knowledge of benefits: affordability)

Basic information about implants to support key messages should also be communicated. This includes:
- Hormonal implants consist of 1-2 small, thin, flexible plastic rods, each about the size of a matchstick.
- Implants are inserted under the skin of a woman's upper arm.
- Implants should be inserted and removed by a skilled provider.
- Implants prevent pregnancy for 3-5 years.
- Implants are a safe, highly effective, and quickly reversible long-acting method that requires little attention after insertion.
- No regular action by the user and no routine clinical follow-up are required.
- Just as there are changes in a woman's body when she is pregnant, users of implants are likely to experience changes which are completely normal, safe, have no effect on fertility and tend to diminish over time. Changes to normal menstrual bleeding patterns is the most common, including irregular bleeding, prolonged bleeding or spotting, heavy bleeding, bleeding or spotting between periods, no bleeding at all or a combination of these patterns. Other possible side effects include headache, acne and weight gain, though again these tend to diminish over time. It's important to remember that most side effects lessen or completely stop within three months of starting a new method. Not all women have these side effects, and these side effects are not a sign of illness.
- Implants are provided at _____ (e.g. any facility where you see this sign....)

PRIMARY AUDIENCE 2: CLINICAL PROVIDERS

OBJECTIVES

By the year 2015, increase the percentage of clinical providers who:

1) Demonstrate accurate knowledge of implants, including benefits and side effects.
2) Effectively counsel and present impartial information on implants including eligibility criteria, side effects, procedure, and effectiveness.
3) Respect clients' right to choose the method that suits them best, regardless of the providers' own values or perceptions of male partner preferences.
4) Report the confidence and resources they need to provide implants.

POSITIONING

The overall positioning for clinical providers will be based on promoting proud, professional providers. This will be operationalized as:

- Pride in position and providing long term solutions to clients
- Pride in having more skills
- Prestige in being seen as knowledgeable and helpful
- Satisfaction in helping women and families in improving their health
- (for private sector)—Satisfied clients will return and refer friends/family
- (for public sector)—Providing quality services reduces patients returning with problems (thereby decreasing work load)

KEY PROMISE

For clinical providers, implants are a highly effective, safe and long acting family planning option that only specially trained clinical providers offer.

SUPPORT STATEMENT

PRIMARY AUDIENCE 2: CLINICAL PROVIDERS

You will gain prestige through satisfied clients who are able to plan their families and reach their goals.

KEY MESSAGES

Key messages for providers should be focused on confident, capable providers that can believe in the safety and efficacy of implants and embrace the concept of helping women (and couples) choose a family planning method that "suits them best".

- Ensure that you have accurate and up-to-date knowledge of implants, including both benefits and side effects; your clients rely upon you as an excellent provider to keep them informed! (Knowledge of benefits: safety/side effects).
- A woman's family planning needs – and method preferences – often change across her lifetime. Taking the time to speak to your clients about their intentions and preferences, and helping them choose the method that is best for them, is the mark of an expert provider (Knowledge: method benefits and changing needs; attitudes: clients' right to choose).
- Implants are a highly effective, safe, and convenient long-term method for timing and spacing pregnancies. Well-timed pregnancies help improve the health and well-being of women and their families (Knowledge of benefits).
- Present appropriate family planning options to each client based on their life-stage, clearly describing method benefits and side effects, then allow the client to choose the method that is best for her. Confident providers support their clients rather than direct them. (Attitudes: clients' right to choose)
- Implants are a safe and appropriate contraceptive choice for young women, including those women who have not yet had children. (Attitudes: appropriate method for young women)
- Speak to clients and their partners about family planning. Many men support their wives in spacing and limiting pregnancies, and appreciate safe, affordable, long-term methods such as implants. (Attitudes: male support for family planning generally and implants specifically)
- As an experienced provider, you can speak to your clients about implants, including benefits and side effects. Providing clear and comprehensible information, and listening to client preferences, will help clients make decisions that are right for them (Self efficacy to counsel).
- You have the training and the experience to correctly insert implants. Your abilities help ensure that your clients have a quick and easy insertion, and are able to access the family planning method they have chosen (Self efficacy to insert after provider training).

As with women, basic information about implants should also be communicated. This includes:

- Hormonal implants consist of 1-2 small, thin, flexible plastic rods, each about the size of a matchstick.

PRIMARY AUDIENCE 2: CLINICAL PROVIDERS

- Implants are inserted under the skin of a woman's upper arm.
- Implants should be inserted and removed by a skilled provider.
- Implants prevent pregnancy for 3-5 years.
- Implants are a safe, highly effective, and quickly reversible long-acting method that requires little attention after insertion.
- No regular action by the user and no routine clinical follow-up are required.
- Just as there are changes in a woman's body when she is pregnant, users of implants are likely to experience changes which are completely normal, safe, have no effect on fertility and tend to diminish over time. Changes to normal menstrual bleeding patterns is the most common, including irregular bleeding, prolonged bleeding or spotting, heavy bleeding, bleeding or spotting between periods, no bleeding at all or a combination of these patterns. Other possible side effects include headache, acne and weight gain, though again these tend to diminish over time. It's important to remember that most side effects lessen or completely stop within three months of starting a new method. Not all women have these side effects, and these side effects are not a sign of illness.
- Implants are provided at _____ (e.g. any facility where you see this sign....)

PRIMARY AUDIENCE 3: NON-CLINICAL PROVIDERS

OBJECTIVES

By the year 2015, increase the percentage of non-clinical providers who:

1) Demonstrate accurate knowledge of implants, including benefits and side effects.
2) Have the confidence and resources they need to effectively introduce implants to community members.
3) Facilitate community dialogue around family planning and long-acting methods.
4) Effectively counsel and present impartial information on implants including benefits, side effects, and effectiveness.
5) Refer clients for more information, insertion/removal, and dealing with side effects.

POSITIONING

PRIMARY AUDIENCE 3: NON-CLINICAL PROVIDERS

The key positioning for non-clinical providers will be that providing information and referral for implants will increase the pride in themselves, prestige among the community and satisfaction in the service they provide:

- Pride in position and providing long term solutions to clients
- Prestige in having the latest knowledge and information about family planning
- Satisfaction in helping women and families in improving their health

KEY PROMISE

If you choose to provide community members with information about long acting family planning, such as implants, you will be seen as a knowledgeable leader in your community.

SUPPORT STATEMENT

Satisfied community members will look to you for information on new methods of family planning and will refer their friends and family members.

KEY MESSAGES

Key messages for providers should be focused on confident, capable providers that can believe in the safety and efficacy of implants and embrace the concept of helping women choose a family planning method that "suits them best".

- Ensure that you have accurate and up-to-date knowledge of implants, including both benefits and side effects (Knowledge)
- Your community depends upon you as a trusted provider to give them information on the fullest choice of FP methods (Pride).
- Taking the time to speak to community members, both male and female, about their intentions and preferences, is an essential part of choosing the method that is best for them (Communication).
- Implants are a highly effective, safe, and convenient long-term method for timing and spacing pregnancies. Well-timed pregnancies help improve the health and well-being of women and their families (Knowledge of benefits).
- Implants are a safe and appropriate contraceptive choice for young women, including those women who have not yet had children. (Attitudes: appropriate method for young women)

PRIMARY AUDIENCE 3: NON-CLINICAL PROVIDERS

- Present information on available family planning options to women, clearly describing method benefits and side effects, then allow the woman to choose the method that is best for her. Confident providers support women rather than direct them. (Attitudes: women's right to choose)
- You can speak to people in your community about implants, including benefits and side effects. Providing clear and comprehensible information, and listening to women's preferences, will help women make decisions that are right for them (Self efficacy to make referrals and counsel).

As with women, basic information about implants should also be communicated. This includes:

- Hormonal implants consist of 1-2 small, thin, flexible plastic rods, each about the size of a matchstick.
- Implants are inserted under the skin of a woman's upper arm.
- Implants should be inserted and removed by a skilled provider.
- Implants prevent pregnancy for 3-5 years.
- Implants are a safe, highly effective, and quickly reversible long-acting method that requires little attention after insertion.
- No regular action by the user and no routine clinical follow-up are required.
- Just as there are changes in a woman's body when she is pregnant, users of implants are likely to experience changes which are completely normal, safe, have no effect on fertility and tend to diminish over time. Changes to normal menstrual bleeding patterns is the most common, including irregular bleeding, prolonged bleeding or spotting, heavy bleeding, bleeding or spotting between periods, no bleeding at all or a combination of these patterns. Other possible side effects include headache, acne and weight gain, though again these tend to diminish over time. It's important to remember that most side effects lessen or completely stop within three months of starting a new method. Not all women have these side effects, and these side effects are not a sign of illness.
- Implants are provided at _____ (e.g. any facility where you see this sign....)

INFLUENCING AUDIENCE 1: MALE PARTNERS

OBJECTIVES

By 2015, increase the percentage of men who:

1) Recognize implants as comfortable, healthy, affordable, socially acceptable and safe
2) Agree that their wife or partner should use implants, if that is her desired method
3) Talk to their partner about fertility and family planning, including implants

POSITIONING

Implants can be positioned as enabling male partners to fulfill their roles as "protector" and "provider" for their family. This can be operationalized in a variety of ways, sensitive to the country context and without reinforcing gender stereotypes. For example:

- Protect: Implants are an effective family planning method to ensure that couples time pregnancies in a way most beneficial to the mother's and children's health.
- Protect: Spacing births sufficiently gives each child a healthy start before the next child arrives and also gives the mother time to recover her strength.
- Provide: Spacing births also helps a couple to be able to provide food, education, and health care for each child.
- Provide: As for women, implants may also be positioned among male partners as affordable, depending on the country context and whether they are available free of charge or at cost, or whether cost is considered a key barrier.
- Care: The decision to get an implant isn't always easy. Partners can make joint decisions and consider the desires of one another when deciding if an implant is the right choice for the couple**.**

**When positioning family planning to men, it is critical that marketing and communications campaigns do not reinforce negative gender stereotypes. While audience insight research points to men's aspirations of being protectors and providers, communications should carefully portray men's roles. Formative research and then pretest focus groups will be critical when developing materials targeted to men that promote positive behavior change without gender stereotyping.*

INFLUENCING AUDIENCE 1: MALE PARTNERS

KEY PROMISE

When you and your partner choose to use implants, you are choosing a safe method to help ensure the health of the mother and your children.

SUPPORT STATEMENT

By choosing implants or another method of family planning you and your partner will be better able to provide for the health and well-being of all your children.

KEY MESSAGES

As with women, key messages for male partners should focus on the benefits. In line with the "Provider" and "Protector" positioning, key messages may include:

- Family planning enables couples to time pregnancies in a way that is beneficial to the mother's and children's health. Speak to your partner about implants, an affordable way for you to ensure your family is healthy and well-cared for (Knowledge of benefits: affordability).
- Family planning enables couples to time pregnancies in a way that is beneficial to the mother's and children's health. Speak to your partner about implants, a safe and effective method to plan your pregnancies and ensure the health of your family (Knowledge of benefits: safety).
- Be like other men in your community who support their wives to practice family planning.
- Encourage your partner to visit a health facility nearby that supplies implants at _____ (e.g. any facility where you see this sign....) (Knowledge: availability).
- Talk to your partner about implants; they offer at least three years of protection against unintended pregnancy for a one-time insertion fee (Knowledge of benefits: affordability).
- Implants are quickly reversible and do not affect return to fertility (Knowledge: benefits)

As with women, basic information about implants should also be communicated. This includes:

- Hormonal implants consist of 1-2 small, thin, flexible plastic rods, each about the size of a matchstick.

INFLUENCING AUDIENCE 1: MALE PARTNERS

- Implants are inserted under the skin of a woman's upper arm.
- Implants should be inserted and removed by a skilled provider.
- Implants prevent pregnancy for 3-5 years.
- Implants are a safe, highly effective, and quickly reversible long-acting method that requires little attention after insertion.
- No regular action by the user and no routine clinical follow-up are required.
- Just as there are changes in a woman's body when she is pregnant, users of implants are likely to experience changes which are completely normal, safe, have no effect on fertility and tend to diminish over time. Changes to normal menstrual bleeding patterns is the most common, including irregular bleeding, prolonged bleeding or spotting, heavy bleeding, bleeding or spotting between periods, no bleeding at all or a combination of these patterns. Other possible side effects include headache, acne and weight gain, though again these tend to diminish over time. It's important to remember that most side effects lessen or completely stop within three months of starting a new method. Not all women have these side effects, and these side effects are not a sign of illness.
- Implants are provided at _____ (e.g. any facility where you see this sign....)

INFLUENCING AUDIENCE 2: EXTENDED FAMILY MEMBERS AND COMMUNITY MEMBERS

OBJECTIVES

By 2015, increase the percentage of extended family/community members who:

1) Recognize implants as comfortable, healthy, affordable, socially acceptable and safe
2) Agree that their daughters-in-law or women in their community should use implants, if that is her desired method

POSITIONING

Implants are an excellent family planning method for the building of stronger and healthier families and communities.

KEY PROMISE

INFLUENCING AUDIENCE 1: MALE PARTNERS

When families and communities support implants as an option for family planning, they support and positively influence the health of their children and mothers.

SUPPORT STATEMENT

By choosing implants or another method of family planning, families in the community will be better able to provide for the health and well-being of all the children.

KEY MESSAGES

As with women, key messages for extended families and community members should focus on the benefits. Key messages may include:

- Implants enable families to time pregnancies in a way that is beneficial to the mother's and children's health.
- Support women in your community who choose to use implants, an affordable/safe way to ensure your community is healthy and well-cared for (Knowledge of benefits: affordability/safety).
- Leaders in our community support women who practice family planning.
- Implants offer at least three years of protection against unintended pregnancy for a one-time insertion fee (Knowledge of benefits: affordability).
- Implants are quickly reversible and do not affect return to fertility (Knowledge: benefits)

As with women, basic information about implants should also be communicated. This includes:

- Hormonal implants consist of 1-2 small, thin, flexible plastic rods, each about the size of a matchstick.
- Implants are inserted under the skin of a woman's upper arm.
- Implants should be inserted and removed by a skilled provider.
- Implants prevent pregnancy for 3-5 years.
- Implants are a safe, highly effective, and quickly reversible long-acting method that requires little attention after insertion.
- No regular action by the user and no routine clinical follow-up are required.
- Just as there are changes in a woman's body when she is pregnant, users of implants are likely to experience changes which are completely normal, safe, have no effect on fertility and tend to diminish over time. Changes to normal menstrual bleeding patterns is the most common, including irregular bleeding, prolonged bleeding or spotting, heavy bleeding, bleeding or spotting between

INFLUENCING AUDIENCE 1: MALE PARTNERS
periods, no bleeding at all or a combination of these patterns. Other possible side effects include headache, acne and weight gain, though again these tend to diminish over time. It's important to remember that most side effects lessen or completely stop within three months of starting a new method. Not all women have these side effects, and these side effects are not a sign of illness. • Implants are provided at _____ (e.g. any facility where you see this sign....)

Step 5: Determine Activities and Interventions

Suggested approaches and activities and illustrative examples are presented here as appropriate choices for communicating to primary and influencing audiences about contraceptive implants. These suggestions are a starting point and close collaboration with communication and creative professionals can help ensure that design and execution are innovative and compelling. Note that myths and misconceptions about implants should not be dealt with through mass media – these are best addressed through interpersonal communication in counseling with providers.

Refer to page 22 for supporting guidance on this step as well as "Step 5" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/fp-step5) for further resources.

Mass Media

INTERVENTION AREA	ILLUSTRATIVE ACTIVITIES	PURPOSE	INTENDED AUDIENCE
Short-form mass media	• Develop TV/Radio Public Service Announcement (PSA) on implants (e.g. of real couples talking about why they choose implants)	Increase product/brand awareness and knowledge of benefits	Women Men
Long-form mass media	• Develop multi-episode TV/radio drama serial • Produce radio call-in shows	Stimulate social dialogue and couple communication Shift social norms	Women Men Extended family Communities Providers (clinical and non-clinical)
Print media	• Develop/adapt take home brochures and/or posters on implants, including available quality service locations	Increase product knowledge / knowledge of where to find quality services	Women Men Non-clinical providers
Digital media and	• Produce SMS service on family planning	Increase product/brand	Women

mHealth	methods, including implants, with information on quality service points for implants counseling and services. The MAMA partnership has developed adaptable messages on implants that are based on WHO and UNICEF guidelines. MAMA messages located on the website are offered free of charge, and any organization can apply to adapt and use the messages in their own local programs. Messages are available through www.mobilemamaalliance.org. • Host family planning hotline, including implants (phone and/or SMS-based) • Launch Facebook and other relevant social media platforms for peer-to-peer communication and support	awareness and knowledge Stimulate social dialogue	Men Non-clinical providers

Clinic-Based Services

INTERVENTION AREA	ILLUSTRATIVE ACTIVITIES	PURPOSE	INTENDED AUDIENCE
Clinic services	• Establish dedicated service-providers for implants • Have a "family planning" counselor (IPC worker) in waiting rooms, to answer questions, provide information, and support women's family planning choices • Hold clinic waiting room dialogues • Develop video for clinic waiting room • Develop and disseminate quality guidelines via professional peer networks or associations • Train providers on face-to-face counseling, including post-partum counseling (implants as	Increase product awareness/knowledge Establish quality standards to ensure good service for clients Improve provider-client counseling and services on implants	Women Clinical providers

	an optional method for family planning/promote healthy birth spacing) • Develop/adapt job aids that focus on key counseling steps and specific messages on implants • Increase the use of new technologies as job aides, e.g. ACE (application for contraceptive eligibility) for Android (https://www.k4health.org/product/ace-mobile-app)		
Social franchising/ service promotion	• Establish network of social franchise providers with set quality standards and denote those who follow these standards with a symbol of quality. • Promote this symbol through mass media and location-specific apps	Establish recognized brand of quality family planning sites that offer implants	Clinical providers Women Men
Digital/distance learning	• Develop/adapt long-distance curricula to include specific information about counseling on implants • Develop short video clips and print frequently asked questions that model counseling and implant insertion and removal that can be disseminated via print, video, smartphones and tablets	Increase knowledge and skills	Clinical and non-clinical providers
Supportive Supervision	• Establish regular supportive supervision visits to trained providers – reinforce skills, correct technique and ensure quality • Remind providers to promote implants • Available to supervise or assist with removals – as gap between training and removals may be	Increase knowledge and skills	Clinical and non-clinical providers

	up to 3 years		

Community-Based Services, Outreach and Community Approaches

INTERVENTION AREA	ILLUSTRATIVE ACTIVITIES	PURPOSE	INTENDED AUDIENCE
CHW outreach	• Recruit and train male and female CHWs to conduct community-based counseling & referral for implants • Provide CHWs with sample implants as part of the communications materials, to give women an opportunity to touch and feel the flexible rods • Develop and produce radio distance learning program for community workers that model positive behaviors and relationships with communities and referral clinics • Establish CHW radio listening groups and/or peer support groups for distance learning program • Develop/adapt materials and job aides to provide guidance on counseling and referral for implants • Develop badges, buttons and other items that support the central positioning and promotion of quality. • Develop formal referral system between CHW and clinics – non-monetary incentives such as allowing referred clients to be seen quickly positively impacts on the prestige of the CHW in the community.	Improve knowledge and skills of CHWs Provide peer-supported learning opportunities Ensure quality counseling and referral Promote quality services/brand recognition Encourage social dialogue	Non-clinical providers

Community approaches	• Hold community theatre and dialogues around reproductive health, maternal and child health, and family planning using satisfied users (and their partners) as key advocates • Show and tell with the flexible rods • Organize discussion groups for men, women and/or couples	Encourage social dialogue Increase social support for implants	Women Men Extended family Communities
Champions	• Identify satisfied users as community advocates • Identify "everyday heroes" - men in the community who support family planning and are helping to ensure the health of their families – and celebrate them at community events and through community and mass media	Encourage social dialogue Increase social support for implants	Women Men Extended family Communities

Structural

INTERVENTION AREA	ILLUSTRATIVE ACTIVITIES	PURPOSE	INTENDED AUDIENCE
Policy and guidelines	• Disseminate guidelines for counseling, insertion, and removal of contraceptive implants as another FP option • Twitter feed on international, national, and local progress toward making contraceptive implants available at community level, local impact, studies/reports published, implementation tips, and other relevant information *Scaling Up Lifesaving Commodities for Women,*	Ensure consistent availability, promotion, and proper use of contraceptive implants as another affordable option for family planning Enable community-level distribution and use of contraceptive implants	District health officials

	Children, and Newborns: An Advocacy Toolkit provides advocacy resources for utilizing the Commission platform to raise awareness and engage stakeholders in addressing commodity-related gaps in policy. See: http://www.path.org/publications/detail.php?i=2381		
Pre-service training	If appropriate for district-level managers: Integrate contraceptive implants counseling, insertion and removal into pre-service training for all providers, including pharmacists, doctors, nurses, midwives, CHWs, etc.	Increase awareness and proper use of contraceptive implants	Pharmacists, doctors, nurses, midwives, CHWs, etc.

Step 6: Plan for Monitoring and Evaluation (M&E)

Refer to page 24 for supporting guidance on this step as well as "Step 6" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/fp-step6) for further resources.

Illustrative indicators for measuring inputs, outputs, outcomes and impact are provided below, with examples of potential data sources:

Women:

- Number of television spots aired on TV (Monitoring- communication channel statistics)
- Proportion of women of reproductive age who believe that implants are a healthy and acceptable option for family planning. (Evaluation- omnibus survey or nationally representative survey)
- Number of implants inserted following demand generation campaign (Evaluation- service statistics)
- Proportion of family planning users using the implant (Evaluation- DHS or nationally representative survey)
- Proportion of women of reproductive age who report that they talked to their spouse about family planning options, including the implant (Evaluation- omnibus survey or nationally representative survey)
- Proportion of women of reproductive age who report that they know where to access information and services for implants (Evaluation- omnibus survey or nationally representative survey)

Providers:

- Number of clinical providers who viewed training video on appropriate contraceptive counseling (Monitoring- communication channel statistics)
- Number of households visited by non-clinical providers (Monitoring- provider self-reported data)
- Number of referrals made by non-clinical providers using counseling cards (Monitoring- provider self reported data)
- Proportion of non-clinical and clinical providers who can accurately report the eligibility criteria for different contraceptive methods (Evaluation- provider self reported data or survey)
- Proportion of clinical providers who report that they have high self-efficacy for provision of implants (Evaluation- provider self reported data or survey)

Partners:

- Number of partners of women of reproductive age who reported viewing TV spots related to family planning and the implant (Monitoring- nationally representative surveys)
- Proportion of partners of women of reproductive age who report that the implant is a healthy and acceptable option for family planning (Evaluation- omnibus surveys or nationally representative surveys)
- Proportion of partners of women of reproductive age who report that they talked to their spouse about family planning options, including the implant (Evaluation- omnibus surveys or nationally representative surveys)

References

Alemayehu, M., Belachew, T., & Tilahun, T. (2012). Factors associated with utilization of long acting and permanent contraceptive methods among married women of reproductive age in Mekelletown,Tigray region , north Ethiopia. BMC Pregnancy and Childbirth, 12(6).

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Eke, A. C., & Alabi-Isama, L. (2011). Long-acting reversible contraception (LARC) use among adolescent females in secondary institutions in Nnewi , Nigeria. Journal of Obstetrics and Gynaecology, 31(February), 164–168. doi:10.3109/01443615.2010.539720

Guttmacher Institute, International Planned Parenthood Federation (2010). Facts on Satisfying the Need for Contraception in Developing Countries. Original source: World Health Organization (WHO) et al. (2010). Trends in Maternal Mortality: 1990 to 2008, Geneva: WHO.

Health Communication Capacity Collaborative (2013). Demand Generation for 13 Life-Saving Commodities: A Synthesis of the Evidence. Baltimore, MD: Johns Hopkins University Center for Communication Programs.

Hubacher, D., Olawo, A., Manduku, C., &Kiarie, J. (2011). Factors associated with uptake of subdermal contraceptive implants in a young Kenyan population. Contraception, 84, 413–417.doi:10.1016/j.contraception.2011.02.007

Kerber, K. J. et al. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Lancet 370, 1358–69 (2007).

Key Findings: Contraceptive Commodities for Women's Health. (2012) Working Paper prepared for the UN Commission on Life Saving Commodities for Women and Children.

Kincaid, D.L., Figueroa, M.E., Storey, D. & Underwood, C. (2007). *A social ecology model of communication, behavior change, and behavior maintenance.* Working paper. Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.

Neukom, J., Chilambwe, J., Mkandawire, J., Kamoto, R., & Hubacher, D. (2011). Dedicated providers of long-acting reversible contraception : new approach in Zambia. Contraception, 83, 447–452.doi:10.1016/j.contraception.2010.08.021

Noar, S. (2006). A 10-Year Retrospective of Research in Health Mass Media Campaigns: Where Do We Go From Here? Journal of Health Communication, 11: 21-42.

Pathfinder International/Ethiopia. (2008). Service delivery-based training for long-acting family planning methods: Client/provider satisfaction assessment.

Ronsman, C. & Graham, W (2007). Maternal mortality: who, when, where, and why. Lancet 368, 1189–1200.

SHOPS/Abt Associates. (2012) Assessment of Private Providers' Knowledge, Attitudes and Practices Related to Long-Acting and Permanent Methods of Contraception in

Singh, S. et al (2009). Abortion Worldwide: A Decade of Uneven Progress, New York: Guttmacher Institute.

The RESPOND project. (2010). Promoting Hormonal Implants Within a Range of Long-Acting and Permanent Methods: The Tanzania Experience (RESPOND Project Brief). New York.

The RESPOND project. (2012). Acceptability of Sino-Implant (II) in Bangladesh: Six-Month Findings from a Prospective Study (RESPOND Project Brief No.7). New York.

United Nations (2011). World Contraceptive Use. New York, NY: United Nations.

UN Commission on Life Saving Commodities for Women and Children (2012). Commissioners' Report.

WHO (2013). Family Planning. World Health Organization Media Centre.http://www.who.int/mediacentre/factsheets/fs351/en/#*Retrieved May 20, 2013.*

Contacts

- Hope Hempstone | United States Agency for International Development (USAID) | hhempstone@usaid.gov
- Stephanie Levy | United States Agency for International Development (USAID) | slevy@usaid.gov
- Zarnaz Fouladi | United States Agency for International Development (USAID) | zfouladi@usaid.gov
- Joanna Skinner | Johns Hopkins University Center for Communication Programs (JHU·CCP) | jskinner@jhuccp.org
- Sanjanthi Velu | Johns Hopkins University Center for Communication Programs (JHU·CCP) | svelu@jhuccp.org

Acknowledgements

The Demand Generation for Reproductive, Maternal, Newborn and Child Health Commodities activities are implemented by the Health Communication Capacity Collaborative (HC3) at Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU-CCP), with support from the RMNCH Trust Fund and the United States Agency for International Development (USAID) , in partnership with Demand Generation Technical Reference Team members, including PSI, International Consortium on Emergency Contraception (ICEC), Jhpiego and other partners.

This document was written by Joanna Skinner, Arzum Ciloglu, and Kate McCracken of JHU-CCP with contributions from Anna Helland, Caroline Jacoby, Lisa Cobb, Alice Payne Merritt, Keris Raisanen, Leanne Wolff, Dana Loll (JHU-CCP), Meg Galas (independent consultant), Zarnaz Fouladi, Hope Hempstone and Stephanie Levy (USAID). Thanks go to Kim Martin and Kathi Fox for editing support.

Photo Credits

All photos included in this publication are courtesy of Photoshare (www.photoshare.org)

(In order of appearance from Audience Profiles)

Ada: A woman carries a bowl of yams on her head on the outskirts of Nigeria's capital, Abuja. © 2012 Akintunde Akinleye/NURHI

Vibha: A young HIV positive woman and her second husband await treatment in the HIV ward of a large municipal hospital in Tamil Nadu, India. Born into a poor family, she was married off at 15 to her first husband (not pictured) who physically abused her, burned her with cigarettes, hit her with pans and threw away her meager income on alcohol. She could not choose her own clothes, go out with friends, or even turn to her family for help because he paid them off. Her husband had many women and infected her with HIV at age 16. She had two children (both HIV negative) before finally divorcing at 19, and her father took her children from her for fear she would infect them. © 2009 Robyn Iqbal

Nana: A young woman with her child in Nungwi, a fishing village in northern Zanzibar, Tanzania. © 1994 Henrica Jansen

Doma: A mother and her children under an insecticide treated net (ITN) in Uganda. © 2007 Bonnie Gillespie

Sara: A family planning client, Moturayo Muritala (R), attends a counseling session with a service provider at Orolodo primary health centre in Omuaran township, Kwara state, Nigeria. © 2012 Akintunde Akinleye/NURHI

Susan: A community worker in Uganda educates a mother on the dangers of malaria. © 2007 Bonnie Gillespie

Joseph: A man in Tanzania cooks in a large metal drum. © 2007 Danny Tweve

Elira: An older woman and a child in Tirana, Albania. © 2010 Brilanta Kadillari

Mr. Asena: A man in Tanzania listens to an HIV/AIDS radio program as part of the STRADCOM (Strategic Radio Communication for Development) project. © 2008 Robert Karam

Suggested citation:

The Health Communication Capacity Collaborative HC3. (2014) *An Adaptable Communication Strategy for Contraceptive Implants.* Baltimore: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs.