HC3 in Action

Enhancing Family Planning Service Delivery through SBC

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HEALTH COMMUNICATION CAPACITY COLLABORATIVE

INTRODUCTION

Family planning (FP) decisions are shaped by many actors. While individuals and couples may choose to plan the timing of their children, experiences at FP facilities, provider behaviors, family support and social or cultural norms can present barriers to achieving the desired family size. To reduce these barriers and improve family planning health outcomes, social and behavior change (SBC) must work in partnership with service delivery.

The Health Communication Capacity Collaborative (HC3) is the United States Agency for International Development's (USAID) flagship program for social and behavior change communication (SBCC). HC3 has taken the lead in aligning SBC and service delivery partners by developing resources for understanding and using strategic communication along the service delivery continuum. HC3 is also integrating SBC and service delivery to improve FP outcomes for youth, women of advanced maternal age, women of high parity and couples. This brief, which is part of the "HC3 in Action" series, describes key examples, challenges and insights from FP service delivery initiatives across the HC3 project.

About HC3

HC3 is a five-year, global project funded by USAID led by the Johns Hopkins Center for Communication Programs (CCP) in collaboration with Management Sciences for Health, NetHope, Population Services International, Ogilvy PR and Internews. It is designed to strengthen developing country capacity to implement state-of-the-art SBCC programs. HC3 fosters vibrant communities of practice at the national, regional and global level that support improved evidence-based programming and continued innovation. More information is available at: http://healthcommcapacity.org.

About the HC3 in Action Series

The HC3 In Action series documents and synthesizes HC3's experiences and lessons learned on topics that cut across the project's diverse portfolio of activities. Each brief draws from HC3's work in 34 countries as well as initiatives, tools and resources developed at the global level.

Acronyms

App	Application
CCP	Johns Hopkins Center for Communication Programs
EPI	Expanded program of immunization
FP	Family Planning
HC3	Health Communication Capacity Collaborative
HTSP	Healthy timing and spacing of pregnancies
I-Kit	Implementation Kit
IVR	Interactive voice response
MCSP	Maternal and Child Survival Program
MSI	Marie Stopes International
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PSI	Population Services International
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SMS	Short message service
USAID	United States Agency for International Development

ADVANCING SBC ACROSS THE SERVICE DELIVERY CONTINUUM

The Integration of SBC and Service Delivery

Integrating SBC and service delivery has been emphasized and attempted in various health projects, but partners have lacked a systematic framework and implementation tools to support this strategic alignment. To create a common reference for this integration, HC3 developed the Circle of Care Model, a conceptual framework for improving service-related outcomes. The model was introduced on June 8, 2017 at the event, "The Critical Role of SBC across the Service Delivery Continuum." Experts presented their experiences in a moderated panel, followed by interactive participant discussions to explore key challenges and potential solutions to integrating SBC and service delivery in family planning (FP) and other health areas.

HC3 also developed the Service Communication Implementation Kit (I-Kit), a resource that helps service delivery project managers increase demand for and uptake of services and improve consistent long-term maintenance of healthy behaviors. In developing this I-Kit, HC3 worked closely with a key group of service delivery partners to ensure that the resource met their needs. The joint effort proved to be so dynamic and productive that HC3 convened periodic meetings in Washington DC of SBC and service delivery partners working in FP and reproductive health as a forum for discussion, debate and collaboration.

The Maternal and Child Survival Program (MCSP) is a regular partner at these meetings. Chelsea Cooper, the SBCC Advisor for MCSP, sees them as "a platform for service delivery and SBC partners to coordinate efforts, learn from each other's expertise, and discuss emerging topics of relevance to our collective work." She adds that it paves the way for better in-country coordination. "The informal working group has certainly made inroads to better coordination in DC, and continued collaboration will improve the interface between partners at the country level."

HC3's partnership with global service delivery partners and development of powerful tools allow SBC and service delivery collaboration to follow a systematic process for maximum integration success and improved health outcomes.

THE CIRCLE OF CARE MODEL
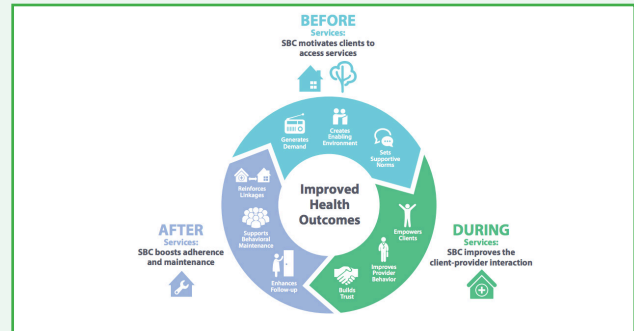
The **Circle of Care Model** shows how service delivery and social and behavior change can work together to improve health outcomes. Using SBC before, during and after services can improve health outcomes by:

- Creating an enabling environment
- Motivating clients to access services
- Improving the client-provider interaction
- Supporting behavioral maintenance

Examples from HC3 country projects in Nepal, Nigeria and Swaziland are used in this video to illustrate the integral role SBC interventions played along the service delivery continuum in achieving positive outcomes.

SERVICE COMMUNICATION I-KIT

Service communication is the use of SBC processes and techniques to motivate health service-related behaviors among intended audiences across the continuum of care—Before, During and After services.

The **Service Communication Implementation Kit (I-Kit)** aims to help service delivery project managers effectively use service communication to enhance the impact of their project. This I-Kit can be used to help increase demand for and uptake of services and improve consistent long-term maintenance of healthy behaviors.

HEALTH WORKER APP AND SERVICE DELIVERY LINKAGES IMPROVE FP COUNSELING IN NEPAL

Optimizing services at health centers in Nepal was a core objective for the HC3 Nepal Smart Jeewan ("Smart Life") campaign. With a focus on married young families, the campaign sought to maximize contacts and referrals among eligible couples using a systematic district intervention model.

The district intervention model included several components to improve counseling: health worker training, a mobile application (app), tripartite meetings and linkages with child immunization clinics. The health worker training, which reached over 700 health workers and 2100 community health volunteers, was designed to orient workers to interpersonal communication and counseling and was reinforced through supportive supervision. Workers were also given Smart Paramarsha ("Smart Counseling"), a mobile app with tailored learning modules on emergency contraception, postpartum FP, client choice, side effects and misconceptions, and migrant worker FP.

Community participation also contributed to improving family planning service delivery. HC3 Nepal facilitated tripartite meetings among communities, health facility management and clinic personnel to increase community ownership of local health services. At these meetings, participants identified changes needed to improve the quality of services and agreed on an achievable plan. Tripartite meetings were conducted in 60 health facilities across the 13 HC3 Nepal districts. So far, 17 health facilities have been formally recognized (and 28 others are near recognition) for enhanced quality services and increasing FP demand.

A critical linkage between FP services and child immunization clinics was established by a system of HC3 peer facilitators. These skilled referral agents systematically attended expanded program of immunization (EPI) clinics, where they counseled young couples on postpartum FP options and ways to avoid early, unplanned pregnancies. EPI clinics served as a vital FP referral opportunity for two reasons. First, since EPI compliance nears 100% in much of Nepal, almost all local young couples could be reached through EPI; and second, the parental care motivations behind high EPI compliance drive not only child immunization behavior but fertility behavior as well. Parents seeking to protect their newborn from disease through immunization easily understand, when counseled briefly, that timely use of FP to avoid accidental pregnancy is a sure way to protect that same child's health as well as their own. The results show the strength of this approach.

THE SMART JEEWAN CAMPAIGN

HC3 Nepal's award-winning **Smart Jeewan ("Smart Life") campaign** is designed specifically to reposition FP as a smart, healthy choice for Nepal's young people. It is implemented at a national scale and in select communities, where local programs are tailored to reach marginalized groups and hard-to-reach families of migrants. See how the campaign was designed and implemented from start to finish on the Health COMpass.

District data on HC3 contacts and referrals to health facilities show that FP-EPI linkages was the most effective touchpoint for married young families. The FP-EPI linkages led to 99,920 contacts and 20,317 referrals from January 2016 to May 2017, more contacts and referrals than home visits or regional events.

HC3 Nepal also worked to improve supply-demand linkages through partnership with SIFPO and service delivery units in districts. This comprehensive district intervention model spotlights the impact of working with facilities, governance, communities and service delivery partners to generate FP demand and raise the quality of health services.

"Now many people know about family planning and spacing their children. Most of them have heard about it from radio and TV and they hear about specific family planning issues through peer facilitators like me."

-Pratima, a peer facilitator

VIDEO AND GUIDE HELP PROVIDERS CHAMPION LARCS FOR YOUTH

Long-acting reversible contraceptive methods (LARCs), are highly effective, but rarely accessed or adopted by youth. Based on formative research findings that showed the key role that health providers play in youth uptake of LARCs, HC3 created a suite of SBC materials that program managers could use to improve providers' attitudes towards youth use of LARCs and their counseling abilities. The suite includes: a provider training video, a video discussion guide, a brochure and series of posters. Since its launch in April 2016, this LARCs for Youth collection has been adapted 29 times for audiences in over 20 countries, showing that these materials fill a need for program managers worldwide.

> *"These materials were crucial to my provider training. I searched but couldn't find anything like them. It saved me tons of time revising these materials instead of writing and producing something on my own. The providers loved the video, and I loved how interactive and impactful my trainings are now because of them!"*
>
> *-Maia, a provider training coordinator*

Table 1 shows how these tools are shaping service delivery in several countries. For example, In Uganda, the video and guide were used as a part of a five-day training for PACE, a local affiliate of Population Services International (PSI). In Madagascar, Projet Jeune Leader translated the video to Malagasy and used it in health worker trainings to strengthen communication between providers and clients. In Ghana, Marie Stopes International (MSI) distributed over 50,000 copies of the brochures and 10,000 copies of the posters in public and private clinics, community mobilization events and tertiary institutions.

LARCS FOR YOUTH TOOLS

#1. BE CLIENT CENTERED

HC3's LARCs for Youth tools improve FP providers' counseling abilities for young clients. They are meant to be adaptable for specific contexts and intervention needs. Program staff wishing to use the tools in their own work can see and request the editable files.

Increasing LARC access can have a crucial impact on youth sexual and reproductive health by reducing unintended pregnancies, unsafe abortions and morbidity and mortality rates (FP2020, Global Census). HC3's LARC materials meet program managers' needs for youth-friendly service delivery and set an example of quality counseling and materials.

> *"By playing a video that features a health provider speaking directly to her peers, urging them to reflect on their own path, and then providing four simple and easy-to-remember tips, participants were able to connect with the content immediately and feel empowered to make changes in their own lives and practices."*
>
> *-Rena Greifinger, PSI*

Country	Organization
Botswana	Ministry of Health and Wellness
Democratic Republic of Congo	Population Services International (Passages Project)
Dominican Republic, El Salvador, Guatemala, Honduras	Johns Hopkins Center for Communication Programs (K4Health Zika)
Ghana	Marie Stopes International (Reducing Maternal Morbidity and Mortality)
Liberia	Jhpiego (Maternal and Child Survival Program)
Kenya	Ipas (Choices for Change Project)
Madagascar	Projet Jeune Leader
Myanmar	Population Services International (Adolescent Health Education and Services Promotion)
Tanzania and Senegal	EngenderHealth (Postabortion Care Family Planning Project)
Uganda	Population Services International (PACE)
United States	Army (Contraceptive Health for Active Duty Youth)

Table 1: Examples of Organizations and Projects Requesting LARC Materials

SMART CLIENT TOOLS EMPOWER CLIENTS TO ACHIEVE FP GOALS

Communication is a core skill for individuals and couples considering FP decisions: communicating with one's partner, communicating with family and friends and communicating with a health care provider. However, women and men are often not equipped with the skills they need to communicate actively and effectively with each other or with FP providers. In order to increase the number of FP clients who are informed, empowered and confident, HC3 developed a set of digital health tools: *Smart Client* (for women) and *Smart Couple* (for both men and women). These tools reach FP clients directly via their mobile phone with information and skills in an entertaining and engaging format. They use interactive voice response (IVR) to deliver a fictional drama, personal stories, examples of "smart client" dialogues and quizzes over a series of 17 calls, along with supporting short message service (SMS) reminders or challenges.

Smart Client and *Smart Couple* increase "smart skills" along the FP service delivery continuum:

Before counseling. Users of the *Smart Client* tool demonstrated significant increases in their likelihood to practice "smart skills" including thinking about desired family size and discussing desired family size and contraception with their partner. The tools also include discussion about different methods and build awareness of rights for voluntary FP and quality counseling.

During counseling. *Smart Client* users were 61% more likely to feel confident discussing FP with a provider after using the tool. Additional "smart skills" promoted throughout the tools include: active participation in the discussion with the provider, raising concerns, openly providing information requested and asking their own questions. The *Smart Couple* tool models male partners being supportive by attending appointments and equally participating during counseling.

After counseling. "Smart skills" include feeling confident to use the family planning method as intended, handling side effects, seeking out information, using the method as long as they want to avoid/delay pregnancy or making the decision to switch to another method, and returning to the provider with concerns or questions. *Smart Client* users were more likely to feel that their husband approves of contraceptive use, demonstrating the skill of ongoing couple communication, promoted by both tools.

A quasi-experimental pre-post design trial was conducted in Kaduna City, Nigeria to assess the effects of Smart Couple among 670 women and 652 men. Nearly all the ideational

SMART CLIENT TOOLS

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Smart Client, Smart Couple is a set of digital health tools aimed at increasing the number of FP clients who are informed, empowered and confident. Smart Client is designed for women of reproductive age and Smart Couple is designed for both men and women. The tools use an entertainment-education approach delivered through interactive voice response (IVR) and SMS. Smart Client and Smart Couple scripts and audio recordings come with use and adaptation guides for other programs interested in using an additional channel to reach their audience and create demand for FP services.

and behavioral indicators assessed increased significantly with higher exposure to the tool. Compared to lower exposure level, higher exposure increased:

- Odds of discussing FP with one's spouse by ten-fold for women and more than 12-fold for men.
- Odds of discussing contraceptive methods with one's spouse by more than nine-fold for women and almost 12-fold for men.
- Odds of discussing the need to visit an FP provider with one's spouse by eight-fold for women and four-fold for men.
- Odds of discussing family size by 170% for women and by 161% for men.
- Support for women who use contraceptives by 94% for women and by 188% for men.

Informed, empowered and confident clients can actively engage in FP counseling rather than rely exclusively on providers to direct and lead discussion and decision-making. They become satisfied FP users and advocates to their friends and family.

PILOT PARTNERSHIPS HELP TOGO AND NIGER MAINSTREAM AMA AND HP PREGNANCY RISKS

Many FP programs emphasize healthy timing and spacing of pregnancies (HTSP) to support pregnancies at the healthiest times. Though they often work to prevent pregnancies before age 18 and pregnancy intervals of less than 24 months, these are only two of the four high-risk pregnancies shown in research. Women aged 35 and older (advanced maternal age or AMA) and women who have had five or more births (high-parity or HP) also have an increased risk of adverse health outcomes including preterm delivery, stillbirths and maternal mortality. Yet an HC3 desk review revealed that little to no work has focused on AMA and HP pregnancies, and providers rarely counsel women about these risk factors.

In response to this gap, HC3 developed the HTSP: AMA and HP I-Kit. The I-Kit was informed by qualitative data on knowledge, attitudes and perceived social norms around AMA and HP pregnancies in Niger and Togo. It includes a set of adaptable communication tools for audiences from all socio-ecological levels: individual, family, peer, community and structural. Two organizations piloted the completed I-Kit: Marie Stopes International (MSI) in Niger and the Association Togolaise pour le Bien-Être Familial (ATBEF) in Togo. Each organization used relevant elements of the I-Kit to incorporate the risks of AMA and HP pregnancies into provider training and outreach.

Both pilot projects successfully mainstreamed AMA and HP topics in routine service provision, community group discussions and even mass media.

HTSP I-KIT

The Risks of an Advanced Maternal Age or High Parity Pregnancy are Dangerous for Mother and Baby.
Family Planning Can Prevent These Dangerous Pregnancies

Talk with Your Client

| ASK your client: | EVALUATE your client's situation: | RESPOND to questions & concerns: |

The Healthy Timing and Spacing of Pregnancies: Addressing Advanced Maternal Age and High Parity in Family Planning Programs I-Kit is designed to help program managers address the risks of pregnancies among women aged 35 and older (of advanced maternal age or AMA) and women having five or more births (high-parity or HP) in their family planning or maternal and child health programs.

The I-Kit is available in English and French and includes nine sample AMA and HP communication tools that improve provider-client interaction as well as structural level factors that influence service, policy and media.

"We used to say, 'the number you want, when you want.' Now we realize we have to nuance that message and make couples aware of risks they might face if they have too many [pregnancies] or too late."

-Anita Kouvahey-Eklu, ATBEF

Pilot Partner Results

MSI-Niger	ATBEF (Togo)
12,700 people reached	3,000 people reached

In Niger, MSI integrated AMA and HP into day-to-day client outreach and tailored counseling for at-risk women. MSI-Niger reported reaching more than 12,700 people with AMA/HP information or counseling during September and October 2016, with nearly 10,000 of those reached through large group education sessions. After holding a one-day workshop with journalists using the I-Kit Guide for Journalists, one TV and one print journalist reported on the August workshop, calling attention to the topic. The pieces ran on Radio-Télévision Sarraounia and in the Enqueteur newspaper, respectively.

"The [HTSP] pilot project brought to light new ways we can help women choose to protect themselves and their children from the known risks of AMA and HP pregnancy."

-Sylvie Ramandrosoa, MSI-Niger

Because of the I-Kit and training, ATBEF community health workers in Togo established AMA and HP as a dedicated topic for rotating community group discussions. ATBEF reached more than 3,000 individuals with their I-Kit activities.

HC3's work in Niger and Togo shed light on two forgotten audiences of HTSP FP programs. The successes of the pilot projects demonstrate that providing local partners with comprehensive, evidence-based tools and technical assistance for AMA and HP audiences can improve provider-client interaction and has the potential to achieve mass sensitization.

PROVIDER BEHAVIOR CHANGE WORKSHOP IMPROVE FP COMMUNICATION CAPACITY IN MADAGASCAR

In many low- and middle-income countries, service providers are critical to improving health in the communities they serve. SBC can be an effective strategy to improve provider performance and health outcomes for the community members they serve.

HC3 conducted literature reviews to identify the factors that improve or inhibit quality care for two types of providers: health care workers and community health workers. Findings from the literature reviews revealed a variety of challenges that providers face in performing their responsibilities. These barriers fall under three categories:

- **Knowledge and competency barriers**—not knowing how to perform assigned tasks.
- **Structural and contextual barriers**—being unable to perform assigned tasks due to constraints.
- **Attitudinal barriers**—lacking the desire to perform assigned tasks.

Drawing from this formative research, HC3 developed the Provider Behavior Change I-Kit for programs designed to improve quality of health care. This I-Kit can be used to understand and prioritize provider barriers and develop an SBC intervention to influence factors that undermine providers' willingness and ability to perform their jobs well.

Once the I-Kit was available, HC3 and MCSP found an opportunity to apply the new tool in Madagascar. The Madagascar Ministry of Public Health sought to improve service delivery and ultimately increase FP and sexual and reproductive health (SRH) service demand. In collaboration with MCSP and the Ministry of Public Health, HC3 held a two-day workshop in Antananarivo from July 26 to 27, 2017.

Elizabeth Serlemitsos, Technical Advisor from HC3, led the workshop. It brought together 36 professionals seeking to understand SBC and its role in provider behavior. The overall goal of the workshop was to strengthen the communication capacity of providers, supervisor and trainers in the health system, non-governmental organizations and partners.

On day one, Elizabeth introduced important SBC concepts including the Socio-Ecological Model and the Circle of Care Model. To begin addressing the service delivery challenge, participants identified problems often encountered when receiving health services. In groups, they conducted root cause analyses exploring issues in provider behavior. Elizabeth shared key research findings on provider behavior, prompting the workshop participants to see providers, not as obstacles, but as a critical audience with behaviors shaped by motivations and challenges like clients. They were encouraged to look beyond traditional skills training

PROVIDER BEHAVIOR CHANGE I-KIT

Provider behavior change seeks to positively influence provider behavior by addressing attitudes, beliefs and norms that undermine providers' willingness and ability to perform their jobs well. SBC plays an important role in improving provider behavior towards clients by approaching providers as the audience for SBC.

The **Provider Behavior Change I-Kit** provides step-by-step guidance on using SBC to change provider behavior and improve client outcomes. This I-Kit allows users to focus on either community health workers or facility-based providers as primary audiences.

for health workers, to other factors that influence providers: opportunity, expectation, ability and motivation.

The second day provided a deeper dive in several elements of the I-Kit. Participants were guided through the four preliminary sections of the I-Kit: Learn, Assess, Determine and Design. Some exercises from I-Kit were conducted, including the needs analysis framework and the checklist for determining the appropriateness of SBC for the specific provider behavior intervention. With examples of effective SBC approaches for both community health workers and facility-based providers, group discussions produced several possible solutions for improving provider behavior. The workshop concluded with next steps for influencing providers to be more supportive of postpartum FP and adolescent SRH (particularly, a parenthood project).

"The workshop was very enriching, mostly in the effort to view service providers not as a problem but as an audience of SBCC "

-Provider behavior change workshop participant

Attendees were given further resources for improving provider behavior and support service delivery partners across a range of health issues, to ensure that attendees could successfully apply ideas from the workshop.

CONCLUSION

When family planning SBC and service delivery partners align, programs are more effective and lead to better population and reproductive health outcomes. In addition to developing resources for systematically integrating SBC into service delivery, HC3 has worked with partners to improve health outcomes for specific audiences. The examples included in this brief illustrate work in action that increased FP referrals in Nepal, increased LARC access for youth worldwide, empowered FP clients with digital health tools, reached AMA and HP audiences in Togo and Niger and addressed provider behavior challenges in Madagascar.

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