Life Saving Commodities
Improving access, saving lives

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

AN ADAPTABLE COMMUNICATION STRATEGY FOR CONTRACEPTIVE IMPLANTS

JULY 2014

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HEALTH COMMUNICATION CAPACITY COLLABORATIVE

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Acronyms

ACE	Application for contraceptive eligibility
CBO	Community-based organization
CCP	Johns Hopkins Center for Communication Programs
CHW	Community health worker
DHS	Demographic and Health Surveys
EWEC	Every Woman Every Child
HC3	Health Communication Capacity Collaborative
ICT	Information and communication technology
IPC	Interpersonal communication
IUD	Intrauterine device
LARC	Long-acting reversible contraception
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NGO	Non-governmental organization
PPP	Public-private partnership
PSA	Public service announcement
RMNCH	Reproductive, maternal, newborn and child health
SBCC	Social and behavior change communication
SM	Social marketing
SMS	Short message service
UN	United Nations
UNCoLSC	United Nations Commission on Lifesaving Commodities for Women's and Children's Health
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

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 (the Strategy) is designed to be useful to multiple audiences, including staff from ministries of health, non-governmental organizations (NGOs) and community-based organizations (CBOs). 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, Lifesaving Commodities in RMNCH (the *I-Kit*) (http://sbccimplementationkits.org/demandrmnch). The *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 four core cross-cutting demand generation areas: addressing the role of gender, a theory-based framework for media selection, 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 (SM) approach. If desired, the strategy can be integrated and expanded into a broader social marketing framework, addressing product, price and place.

Thirteen Lifesaving Commodities for Women and Children

In 2010, the United Nations (UN) Secretary-General's *Global Strategy for Women's and Children's Health* (the Global Strategy) highlighted the impact that a lack of access to lifesaving commodities has on the health of women and children around the world. The Global Strategy called on the global community to save 16 million lives by 2015 by increasing access to and appropriate use of essential medicines, medical devices and health supplies that effectively address the 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 Lifesaving Commodities (UNCoLSC) for Women's and Children's Health (the Commission) was formed in 2012 to catalyze and accelerate reduction in mortality rates of both women and children. The Commission identified 13 overlooked lifesaving commodities across the RMNCH "Continuum of Care" that, if more widely accessed and properly used, could save the lives of more than six 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)

Figure 1: 13 Lifesaving Commodities

Reproductive Health		
 **Female Condoms**	 **Contraceptive Implants**	 **Emergency Contraception**
Prevent HIV and unintended pregnancy: A female condom (FC) is a plastic pouch made of polyurethane that covers the cervix, vagina and part of the external genitals. FCs provide dual protection by preventing STI infection, including HIV, and unintended pregnancies.	**Prevent unintended pregnancy:** Contraceptive implants are small, thin, flexible plastic rods inserted into a woman's arm that release a progestin hormone into the body. These safe, highly effective, and quickly reversible contraceptives prevent pregnancy for three to five years.	**Prevent unintended pregnancy:** The emergency contraceptive pill is the most widely available emergency contraceptive in developing countries. It is optimally taken in one dose of 1.5mg as soon as possible after sexual activity. An alternative product of 0.75mg is also widely available.
Maternal Health		
 **Oxytocin**	 **Misoprostol**	 **Magnesium Sulfate**
Post-partum hemorrhage: WHO recommends oxytocin as the uterotonic of choice for prevention and management of postpartum hemorrhage.	**Post-partum hemorrhage:** In settings where skilled birth attendants are not present and oxytocin is unavailable, misoprostol (600 micrograms orally) is recommended.	**Eclampsia and severe pre-eclampsia:** WHO recommends MgSO4 as the most effective treatment for women with eclampsia and severe pre-eclampsia.
Child Health		
 **Amoxicillin**	 **Oral Rehydration Salts**	 **Zinc**
Pneumonia: Amoxicillin is an antibiotic that is used to treat pneumonia in children under five. Amoxicillin is prepared in 250mg scored, dispersible tablet (DT) in a blister pack of 10 DTs.	**Diarrhea:** Oral rehydration salts (ORS) is a glucose-electrolyte solution given orally to prevent dehydration from diarrhea. ORS is packaged in sachets of powder to be diluted in 200 ml, 500 ml or 1 liter of fluid, prepared to an appropriate flavor.	**Diarrhea:** Replenishment with zinc can reduce the duration and severity of diarrheal episodes. Zinc is prepared either in 20mg scored, taste masked, dispersible tablets or oral solutions at concentration of 10mg/5ml.
Newborn Health			
 **Injectable Antibiotics**	 **Antenatal Corticosteroids**	 **Chlorhexidine**	 **Resuscitation Device**
Prevent newborn sepsis: WHO recommends benzlypenicillin and gentamicin, in separate injections, as first-line therapy for presumptive treatment in newborns at risk of bacterial infection.	**Prevent pre-term RDS:** Antenatal corticosteroids are given to pregnant women who are at risk of preterm delivery to prevent respiratory distress syndrome in babies born in pre-term labor.	**Prevent umbilical cord infection:** Chlorhexidine digluconate is a low-cost antiseptic for care of the umbilical cord stump that is effective against neonatal infections.	**Treat asphyxia:** Birth asphyxia, or the failure of a newborn to start breathing after birth, can be treated with resuscitation devices.

Demand Generation: An Overview

What is Demand Generation?

Demand generation increases awareness of and demand for health products or services among an intended audience through social and behavior change communication (SBCC) and SM 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 or 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 salts (ORS) and zinc instead of other anti-diarrheal medicines).

When well designed and implemented, demand generation programs 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.
- 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 advisable 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 Lifesaving 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 the care-seeking behaviors of women and families.

Figure 2: Audiences of Demand Generation

Provider-focused	Provider and End-user
☐ Oxytocin	☐ Female condoms
☐ Magnesium sulfate	☐ Implants
☐ Injectable antibiotics	☐ Emergency contraception
☐ Antenatal corticosteroids	☐ Misoprostol
☐ Resuscitation equipment	☐ Chlorhexidine
☐ Amoxicillin	☐ ORS
	☐ Zinc

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 then 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 (SM). SM 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 their 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.

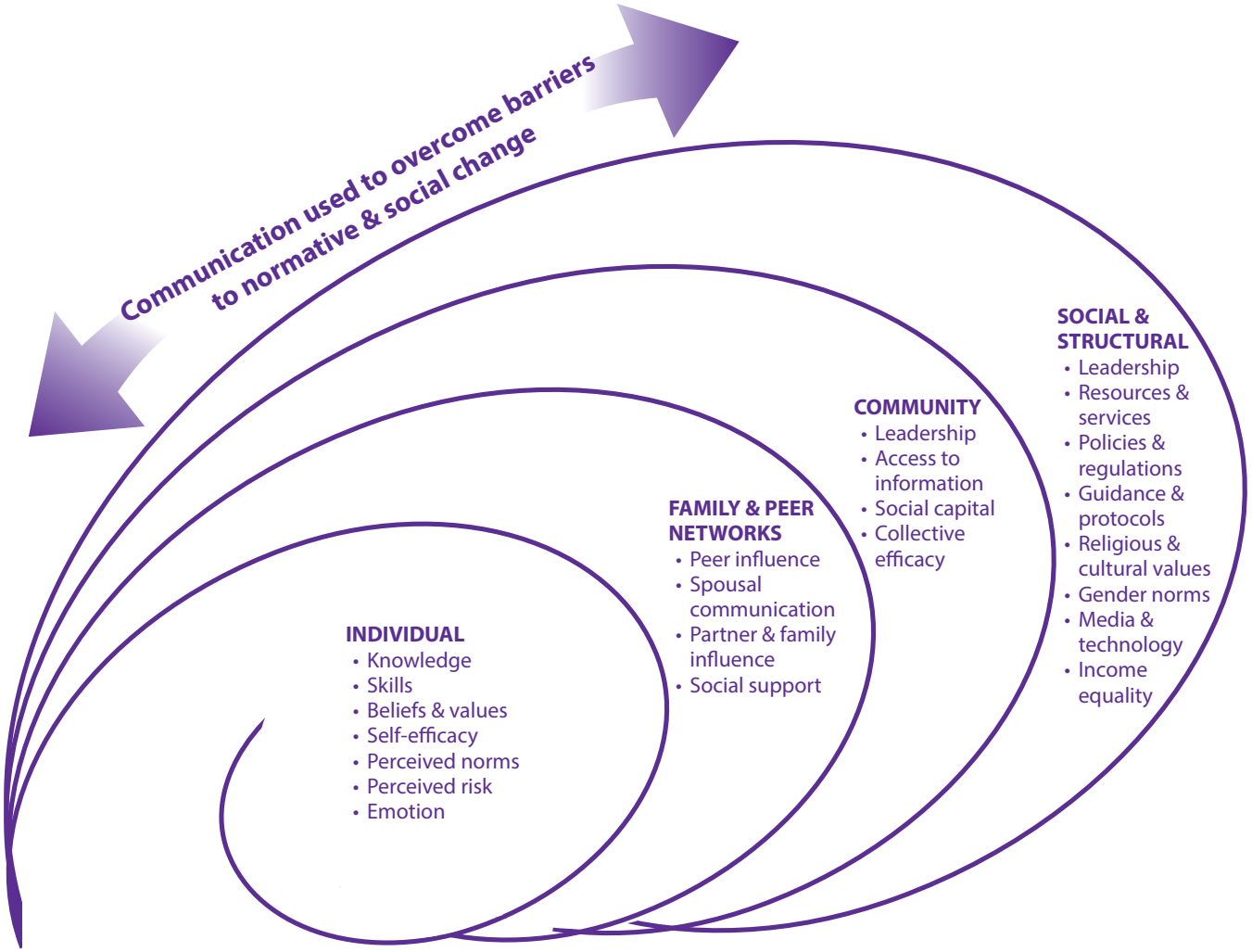
Information and Communication Technologies (ICTs). ICTs refer to electronic and digital technologies that enable communication and promote the interactive exchange of information. ICTs are a type of media, which include mobile and smart phones, short message service (SMS) and social media, such as Facebook 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, Figueroa, Storey, & Underwood, 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 begin 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 that influence the current demand and utilization of a priority RMNCH commodity, including those affected and their perceived needs; 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 lifesaving 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?"

The situation analysis should also examine the attitudes, values, interests, aspirations and lifestyle of the intended audiences. This information, called psychographics, allows for a better understanding of what motivates and what hinders the intended audiences' decisions and actions. Psychographics provide character sketches of the intended audiences that go beyond demographic information (sex, age, education, parity, etc.) and help to build a fuller picture of the audiences as individuals and how they may be nested within and influenced by their community.

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 underutilized 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/), 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 Nielson (http://www.nielsen.com/us/en.html). RMNCH policies and guidelines also may assist in analyzing the situation.

If existing data, particularly on social and behavioral drivers and psychographics, 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. Similarly, for all audiences (providers and end users), it may be especially important to conduct formative research to develop realistic psychographics.

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? If registered, what brands? If not registered, what is the registration process—e.g., time, requirements?
- 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 sectors?
- 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 five to ten 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 counseling, 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 is aware of contraceptive implants?
- What proportion of providers, women, men and other audiences has 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 norms 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 by the 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 and child health) 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 contraception 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?

Psychographics
- What do providers, women and their partners' value? What are their core beliefs?
- Who and what influences providers, women and their partners' decisions and behaviors?
- What dreams do providers, women and their partners have? What do they aspire to in life?
- What are providers, women and their partners' biggest worries? What fears keep them up at night?
- How do providers, women and their partners spend their days? Where do they go? What do they do? What are their hobbies and habits?
- How do providers, women and their partners perceive themselves? How do they want to be perceived by others?

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, communications programs will be more successful if they focus on the top few 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 on the next page.

	Current Behaviors	Primary Barriers to Desired Behavior	Primary Benefits of Desired Behavior
End user/ community members (e.g. women, men, caregivers)			
Providers (including 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's 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 three to five 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 percent of non-users of a family planning method discussed family planning with their male partner compared to 68 percent of current users.	To date, family planning interventions essentially targeted women and considered male partners as an influencing audience. Yet, contraceptive prevalence rate remained very low, between 6 percent and 7 percent. A shift of focus is required.	Addressing men as a primary intended group rather than just an influencing audience becomes a strategic priority.

Source: Population Services International, n.d. 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. A vision statement sets forth the direction the strategy should follow and defines clearly and succinctly how the demand generation activities will affect the broader commodity and health environment. The vision should paint a mental picture of a desired scenario in the future.

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 for the commodity once the demand generation strategy is successfully implemented and clarifies the goal of the demand generation strategy. The shared vision ensures that all stakeholders are working toward the same goal and guides the strategy design and development process.

In addition, a true vision should be realistic, concrete and attainable given the resources available. The vision should also communicate enthusiasm, be inspirational, and foster commitment and dedication from stakeholders toward the shared goal.

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

An example of a vision statement for contraceptive implants may be:

Women, their partners and their providers recognize contraceptive 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

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.

Using key findings collected from the situation analysis, the first step in audience segmentation is to answer 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—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 on the next page can be helpful.

	Primary Audience Influenced	Estimated Power of Influence (Low, Moderate, Strong)	Attitude Toward 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—is 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. They 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 psychographics, such as current behaviors, motivation, emotions, values, attitudes, preferred sources of information and access to communication channels, 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.
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 intended 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.
- 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) are best considered and selected in cooperation 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 also is important to consider linkages with other new or existing programs and systems, both those directly related to demand and those less closely connected but 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 Guide to Public-Private Partnerships in Increasing the Demand for RMNCH Commodities* (available at http://sbccimplementationkits.org/demandrmnch/public-private-partnerships); for 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—e.g., traditional government or local religious endorsement—to ask for greater resources, encourage allocating resources equitably and 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 *How to Mobilize Communities for Health and Social Change* (Howard-Grabman & Snetro, 2003), 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 and digital technologies, including computing and telecommunications technologies, which enable communication and promote the interactive exchange of information. ICTs also include mobile and smart phones, the use of SMS, and social media, such as Facebook, Twitter, LinkedIn, blogs, e-Forums and chat rooms. This approach also includes websites, emails, 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 a small to moderate effect size not only on health knowledge, beliefs and attitudes, but also on behavior (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 toward 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)

Monitoring and Evaluation (M&E) is a critical piece of any program activity because it provides data on the program's progress toward 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—e.g., indicators, sample, tools, who will monitor, frequency of data collection. 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 intended audience.

A full M&E plan should then be developed as a separate program document. Developing an M&E plan should outline what indicators to track, how and when data will be collected, and what will happen to the data once they have 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 function of the program. To measure cause and effect, larger program-specific data collection activities geared toward 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—about 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 of contraceptive implants for family planning). • Qualitative data (focus group discussions, in-depth interviews, photo narrative, 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 changes in audiences' opportunity, ability and motivation to use contraceptive implants, and the extent to which these changes correlate with program exposure.	Measure changes in audiences' behavior and the extent to which these changes correlate with program exposure.	Measure changes in health outcomes.
Example: Number of radio spots aired on family planning methods, including contraceptive implants.	Example: Proportion of women of reproductive age who report that they know where to access information and services for contraceptive implants.	Example: Proportion of family planning users using contraceptive implants.	Example: Reduction in the percentage of unintended pregnancies in women of reproductive age.

Key issues to consider when developing indicators include:

Disaggregation: 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 toward acceptability of the commodity.
- *Age*–At minimum, programs should be able to report data separately for beneficiaries ages 15–19, 20–24 and 25–49 years old, which are the standard DHS age groups to capture major differences in these populations. Based on audience segmentation at country level, programs may wish to disaggregate the 25–49 year 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 caregiver who has previously sought out and received treatment for pneumonia in a child may be more interested and willing to answer a survey about childhood pneumonia compared to someone who has had no exposure.
- *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 toward 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 15 for supporting guidance on this step, as well as "Step 1" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-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 86 million unintended pregnancies worldwide, 41 million of which end in induced abortion and about 11 million of which are considered unsafe abortions in non-medical settings (Singh, Sedgh, & Hussain, 2010). There are an estimated 222 million women with an unmet need for contraception and family planning (UN, 2011). Although contraceptive use has steadily increased globally 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; Ronsmans & 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, switch methods when life circumstances change and meet their contraceptive intentions. Many who currently use contraception—and would not like to have more children—do not have access to long-acting and permanent methods. For women who live far from health services or 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. Globally, among married women between the ages of 15 and 49 years old, 53 percent use a modern method of contraception, but less than one percent use contraceptive implants.

Commodity Context

Hormonal implants consist of small, thin, flexible plastic rods—each about the size of a matchstick—that 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. The 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 US $8.00–18.00 per unit. Two devices are currently prequalified by the World Health Organization (WHO). The most common types include:

- **Jadelle®** by Bayer Pharma (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)®** is currently marketed under various trade names including Zarin® by Pharm Access Africa, Ltd., Femplant® by Marie Stopes International and Trust® by DKT Ethiopia (these are not yet prequalified by WHO) – two rods each containing 75 mg of levonorgestrel, effective for at least four years.
- **Implanon®** by Merck/MSD (WHO prequalified) and Nexplanon® by Merck/MSD – 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®** was discontinued in 2008 – it was comprised of six rods each containing 36 mg of levonorgestrel, effective for five to seven years.

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

Given the up-front cost of implants and their high level of effectiveness and 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 those who are living with HIV, smoke cigarettes, are over the age of 35, have just had an abortion, have diabetes, are at risk for cardiovascular disease (including those with high blood pressure), are lactating mothers and/or are adolescents. Women on antiretroviral therapy (ART) should discuss the use of implants with their doctor in case of a possible drug interaction, which could lead to somewhat reduced implant effectiveness. Implants can be initiated immediately after childbirth if a woman is not breastfeeding or 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. This means that if either the method or the other needed instruments and supplies are unavailable, then the implants services as a whole are 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 (UNFPA, 2012).

Audience and Communication Analysis

A recent global review 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 (HC3, 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 (EngenderHealth/The RESPOND Project, 2010, 2012; Hubacher, Olawo, Manduku, & Kiarie, 2011). In Ethiopia, implants were found to overcome a significant barrier among women seeking family planning services, but hesitant to expose their bodies, because it does not require pelvic examination (Pathfinder International 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, many sexually active adolescent students did not use long-acting methods—including implants, IUDs and injectables—because they believed those methods could interrupt pregnancy or cause infertility, or because of fears (e.g., side effects) and/or religious and cultural barriers (Eke & Alabi-Isama, 2011). Fear of side effects was also found in Bangladesh, especially concerning changes in menstrual patterns (EngenderHealth/The RESPOND Project, 2012). In Tanzania, research revealed concerns about painful insertion and fears it could cause cancer and weight loss or weight gain (EngenderHealth/The RESPOND Project, 2010).

Provider knowledge and bias: Although there was little evidence of the 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 a 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—although they 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 to this type of contraception 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 providers, such as lack of skilled providers, provider lack of knowledge and/or bias, and commodity supply issues (Neukom, Chilambwe, Mkandawire, Kamoto, & Hubacher, 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 86 million unintended pregnancies worldwide, 41 million of which end in induced abortion and about 11 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 and 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 (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 family planning 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/ch-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.

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/ch-step3/) for further resources.

Primary and Influencing Audience Segments *(with rationale for segment selection)*

PRIMARY AUDIENCES

Primary audience 1: Women of reproductive age (with sub-audiences—e.g., by life-stage or 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 allowing 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 wellbeing 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 do not want more children, but may not be ready for permanent methods.

Primary audience 2: Clinical providers (public and private)—Their bias and lack of knowledge on implants and other family planning options similar to implants, have been identified as key 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)—A front-line 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. They should be as knowledgeable about all family planning options, including implants, as clinical providers since non-clinical providers are the link connecting the community with health services at health facilities.

INFLUENCING AUDIENCES

Influencing audience 1: Male partners of women of reproductive age—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

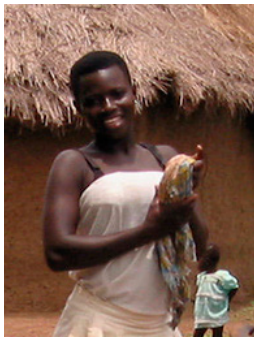
Ada, 19, young unmarried woman living in Abuja, Nigeria

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. Ada earns enough money to pay for her cell phone and 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. Ada sees herself as someone who can go far with hard work and determination. 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, but is not ready to begin a family just yet.

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

Vibha, 21, newly married woman living in 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. She is responsible for cleaning and cooking for her husband and his family, and 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, mother living in Mbale, Uganda

Nana and her husband have one young son, eight 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 an emergency would likely drain their family resources. They are saving to give their children a good education and 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, mother living in Tanga, Tanzania

Doma has four children and 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 wellbeing. Her husband works in the port in Dar es Salaam and comes home once a month. Doma is a good cook and 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, 32, 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 ask her advice on counseling young mothers. Sara's pride shows in her dedication to her work and 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 the information they need to make the best choices. 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 ability to insert the implant so does not mention implants very often as a family planning option. She is not sure if implants are a good idea for young women who have not had a baby. However, Sara is open to learning more about other family planning methods, even those that require clinical skills, if she is given in-service training.

Primary Audience 3: Non-Clinical Providers

Susan, 28, 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, because she is a member of the community that she serves, she has some of the same attitudes, social norms and beliefs that prevent her from talking with certain clients about contraceptives. 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 Dar es Salaam, 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 to both of them 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: Extended Family Members and 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 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 asks 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 Bukadea, 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/ch-step4/) for further resources.

Primary Audience 1: Women of Reproductive Age

Objectives

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

1. Recognize contraceptive 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, while 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 three to five 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 three to five 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.

Other key positioning possibilities are:

Implants are *flexible*—they work for women at all different stages of their life. They are an excellent choice for all kinds of women in all stages of parity. Implants are practical for young women, including adolescents, and women with no children who wish to delay first birth, but still preserve their fertility; low-parity women who want to space the birth of their next child; breastfeeding women who have few good options available to them; women living with HIV; women who just had an abortion; and women thinking about or deciding to limit births, with the option to remove if they change their minds.

Implants also may be positioned as *affordable*, depending on the country context and cost—e.g., are available free of charge or at cost, or if cost is considered a key barrier to family planning use. Implants are a one-time cost every three to five years, which, when spread out over that 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)
- 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 do not 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 do not 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)

Key Messages (continued)

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 time to focus on your family. (Knowledge of benefits: long-acting).
- Choose implants; once it is inserted, you do not have to think about family planning and can focus on what is 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)
- Implants are quickly reversible and do not affect return to fertility. (Knowledge: benefits)
- Implants are 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 do not have to think about family planning and can focus on what is 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, including:

- Hormonal implants consist of one to two 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 three to five 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 are 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, although these too tend to diminish over time. It is 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 and/or 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

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."

Illustrative examples include:

- 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, and 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)

Key Messages (continued)

- 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 one to two 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 three to five 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 are 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, although these too tend to diminish over time. It is 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

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."

Illustrative examples include:

- 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 family planning 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)
- 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)

Key Messages (continued)

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

- Hormonal implants consist of one to two 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 three to five 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 are 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, although these too tend to diminish over time. It is 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 the cost of the implants, whether available free of charge or at cost—if cost is considered a key barrier.
- Care: The decision to get an implant is not 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.*

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 wellbeing 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.

Key Messages (continued)

- 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 one to two 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 three to five 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 are 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, although these too tend to diminish over time. It is 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 their desired method.

Positioning

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

Key Promise

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 one to two 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 three to five 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 are 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, although these too tend to diminish over time. It is 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

Refer to page 21 for supporting guidance on this step, as well as "Step 5" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-step5/) for further resources.

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.

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).	To 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.	To stimulate social dialogue and couple communication. To shift social norms.	Women Men Extended family Communities Clinical and non-clinical providers
Print media	Develop/adapt take home brochures and/or posters on implants, including available quality service locations.	To increase product knowledge and/or knowledge of where to find quality services.	Women Men Non-clinical providers
Digital media and mHealth	• Produce SMS service on family planning 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.	To increase product/brand awareness and knowledge. To stimulate social dialogue.	Women 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 postpartum counseling (implants as 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).	To increase product awareness/ knowledge. To establish quality standards to ensure good service for clients. To improve provider-client counseling and services on implants.	Women Clinical providers
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.	To 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.	To 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 up to three years. (Clinical providers only)	To increase knowledge and skills.	Clinical and non-clinical providers

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 and 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.	To improve knowledge and skills of CHWs. To provide peer-supported learning opportunities. To ensure quality counseling and referral. To promote quality services/brand recognition. To 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.	To encourage social dialogue. To 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.	To encourage social dialogue. To 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 family planning 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, 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	To ensure consistent availability, promotion and proper use of contraceptive implants as another affordable option for family planning. To enable community-level distribution and use of contraceptive implants.	District health officials
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.	To 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 23 for supporting guidance on this step, as well as "Step 6" on the Demand Generation Implementation Kit (http://sbccimplementationkits.org/demandrmnch/ch-step6/) for further resources.

The following indicators (including potential data sources) are used for measuring program inputs, outputs, outcomes and impact.

Women:

- Number of television spots aired on TV that related to family planning and contraceptive implants. (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 contraceptive implants. (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 contraceptive implants. (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 contraceptive implants. (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 contraceptive implants. (Evaluation – omnibus surveys or nationally representative surveys)

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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

Heather Chotvacs | Population Services International (PSI) | hchotvacs@psi.org

Sanjanthi Velu | Johns Hopkins University Center for Communication Programs (CCP) | svelu1@jhu.edu

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