

Section 1: Why Focus on AMA and HP Pregnancies

While much HTSP work to date has focused on delaying early pregnancies and safely spacing birth-to-pregnancy intervals, less attention has been paid to AMA and HP, even though research has shown a number of serious adverse health outcomes. **Table 1** shows the adverse health outcomes that are common for AMA and HP, and those unique to each. The results of these complications can be quite serious, particularly in settings without consistent or easy access to quality health care.

Table 1: Adverse health outcomes associated with AMA and HP pregnancies

Advanced Maternal Age Pregnancies	High Parity Pregnancies
Birth and chromosomal abnormalities	Anemia
Fetal (especially respiratory) distress	Fetal malpresentation
Low or elevated birth weight	Macrosomia/elevated birth weight (often due to gestational diabetes)
	Placental complications
	Postpartum hemorrhage
Maternal hypertension	
Gestational diabetes	
Intrauterine fetal death and stillbirth (due to complications from other conditions, such as maternal hypertension, anemia, or pre-term delivery)	
Caesarean section (required when vaginal delivery is considered too difficult or dangerous due to any of the conditions listed here)	
Preterm delivery	
Maternal mortality (due to complications from other conditions, such as postpartum hemorrhage, hypertension or complications from a Caesarean delivery)	

Women, men and communities often are aware of at least some of these problems but not of their association with the mother’s age and parity. HP and AMA are prevalent in many countries in sub-Saharan Africa, where a large number of women give birth after age 35 and a large number of women are HP.

If FP messages focus on properly spacing between births, but fail to address preventing AMA births, women could continue to give birth well past age 35 as they aim to increase spacing between births. Similarly, if birth spacing messages do not include information on the risks associated with having many births, women could continue to have children well past the number that is safe for both them and their children.

High incidence of AMA and HP births and the many adverse health outcomes of these births demonstrate a clear need for programs that include tailored messages for women at risk, including women who are already AMA or

HP, and women “approaching” AMA and HP. In this I-Kit a woman is considered to be “approaching” AMA or HP if she will turn 35 in the next two years, or if her next birth will be her fifth.

Learning about the risks associated with AMA and HP pregnancies can motivate women and couples to seriously consider modern contraception to prevent these dangerous types of pregnancy.



Resources

- A summary of the evidence is displayed in the Infographic tools (see **Annex L**).
- A review of AMA and HP literature, **Engaging Families for a Healthy Pregnancy** (<http://www.healthcommcapacity.org/wp-content/uploads/2014/03/HTSP-AMA-HP-Assessment-Final-Report-approved-21Mar14.pdf>)
- A review of DHS data, in French and English: <http://healthcommcapacity.org/hc3resources/healthy-timing-spacing-pregnancy-evidence-review-dhs-secondary-analysis/>

Section 2: Understand the Local Situation for AMA and HP Pregnancies

Programs developed with a complete understanding of the issue being addressed, the people affected and their environment are likely to have greater impact than programs that are not. To understand the local situation for AMA and HP, it is helpful to answer key questions about your community before starting an HTSP program, such as:

- What proportion of births are AMA? What proportion are HP? What proportion are both?
- How have the rate of AMA or HP pregnancies changed over the years in your community, and why have these changes occurred?
- What size family do women and men desire? At what life stage do women and men start planning their family, start having children, or make decisions on whether or not to use FP?
- How much do women at risk of AMA and HP pregnancies, their male partners, providers and other audiences know about the risks of AMA and HP?
- What is the typical profile of a woman who has an AMA or HP pregnancy?
- Why do women have AMA or HP pregnancies?
- How common is it for a woman or couple to **not** have an AMA or HP pregnancy in your community? What is the typical profile of such women or couples (e.g., education, income, social status)? How does the community perceive such women or couples?
- What are the perceived barriers to modern FP method access and use? How do these barriers differ for AMA or HP women, or women approaching AMA or HP?
- Under what circumstances is it acceptable for women at risk to use modern FP methods?
- Who are the stakeholders and gatekeepers who influence FP use among women at risk?
- What are the main challenges for providers regarding provision of modern FP methods to women at risk?
- Do providers offer clients long-acting reversible contraception and permanent methods (LARC/PM) as part of a range of available contraceptive options?
- Are AMA and HP clinical and counseling guidelines available?
- Through what channels (including media and interpersonal) do providers, women and their partners prefer to receive health-related information?
- What communication materials and programs already exist related to AMA and HP?
- What gaps in tools exist, especially related to preferred communication channels?

Where to Find This Information

Answers to these questions can often be found in existing data, such as **Demographic and Health Surveys** (DHS) (<http://dhsprogram.com/publications/publication-search.cfm>) or **Multiple Indicator Cluster Surveys** (MICS) (<http://mics.unicef.org/surveys>), quantitative and qualitative research conducted by NGOs, or private sector market research.

If existing data – particularly on the non-structural factors that drive behavior – are not sufficient, are outdated or do not provide enough insight, you may want to conduct your own formative research through surveys, focus groups or interviews.



Resources

- The **Guide for Researchers: Conducting Qualitative Research on AMA and HP Pregnancy** included in this I-Kit (**Annex E**) can be adapted to conduct primary qualitative research on AMA and HP in your country.
- Additional information on conducting qualitative research is provided in guide on **How to Conduct Qualitative Formative Research**: <http://www.thehealthcompass.org/how-conduct-qualitative-formative-research>
- Also see the **Guide for Selecting a Formative Research Method**: <http://www.thehealthcompass.org/sbcc-tools/guide-selecting-formative-research-method>

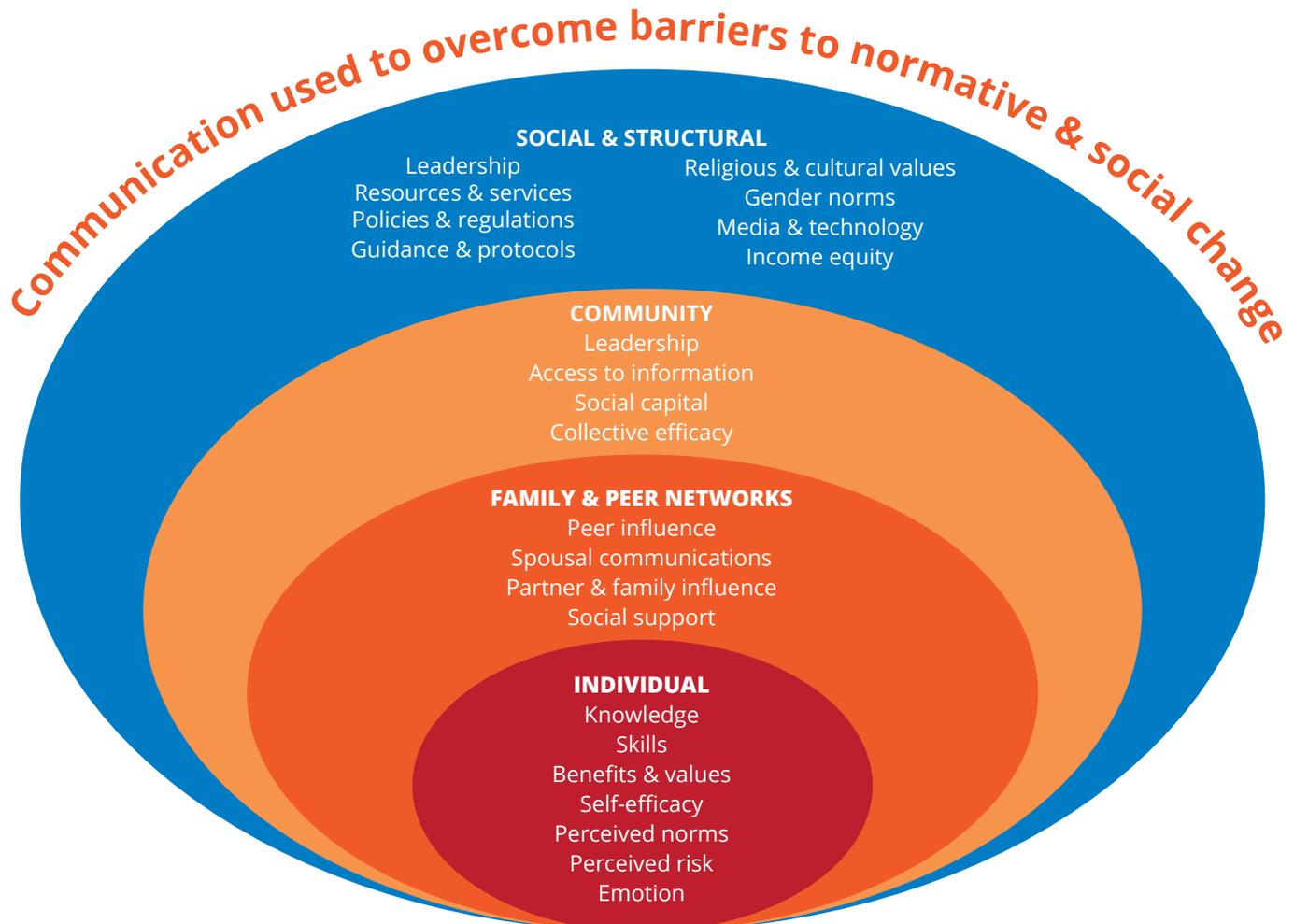
Section 3: Use SBCC to Address AMA and HP Pregnancies

What Influences People’s Behavior?

A person’s behavior is influenced by many factors at the individual level and beyond. The levels of influence can be summarized by the **Socio-Ecological Approach** (Figure 1).

This approach recognizes that behavior change can be achieved through activities that intervene at four levels: individual, interpersonal (family/peer), community and social/structural.³

Figure 1: Socio-Ecological Approach



At each level, there are factors that affect behavior in a positive way (facilitators) and factors that affect behavior in a negative way (barriers). Consider the example of women who are nearing 35 years old or who are approaching their fifth birth. Your program wants to encourage these women to avoid future pregnancies or get the extra care they need to help ensure the health of both the mother and the child. Here are some of the factors at each level of the Socio-Ecological Approach that can influence these women and their ability to stay healthy.

³ Bronfenbrenner, 1979; Kincaid, Figueroa, Storey & Underwood, 2007



At the **individual** level, women need information and skills related to the risks of AMA and HP, including knowing where to get information, knowing how to access services offering FP methods and counseling, and knowing how to negotiate and use the FP method she chooses.



At the **family and peer** level (also called “interpersonal”), women need husbands, friends, siblings and family members to whom they can turn to for accurate information and support.



In the **community**, women need support and an enabling environment to get information about AMA and HP pregnancy risks and FP methods. They may also need reassurance that there will be no negative consequences from the community for accessing services, using FP methods or choosing whether and when to have children.



At the **social/structural** level, women need supportive norms around gender and relationships, including spousal communication and shared decision-making. They also need norms that support smaller family size as a way to ensure maternal and child health, financial security, and/or happiness. Finally, they need religious leaders who acknowledge the benefits of HTSP, and policies that support affordable, high-quality FP methods and services that are accessible to everyone.



Reminder

To most effectively change behaviors, communication efforts should address factors at each level.

Since it may not always be possible for a single organization to do so, it is important to build partnerships and collaborate with organizations and institutions that operate at the levels that your organization does not, and to strategically focus efforts on those barriers and facilitators that are most likely to lead to change.

Develop an SBCC Strategy to Effect Change

Previously known as behavior change communication (BCC), SBCC is an approach that promotes and facilitates changes in knowledge, attitudes, norms, beliefs and behaviors. The terms BCC and SBCC are similar – both refer to a series of activities and strategies that promote healthy patterns of behavior. The word “social” has been added to BCC to indicate that, for improved health outcomes, it is necessary to support broader social change. Throughout this I-Kit, the term SBCC will be used, rather than BCC.

It is important to use a strategic, systematic SBCC approach to analyze the problem, define key barriers and motivators to change and design and implement a comprehensive set of interventions to support and encourage positive behaviors. A communication strategy provides the guiding design for SBCC campaigns and interventions and ensures that:

- Communication objectives are set
- Intended audiences are identified
- Consistent and relevant messages are determined for all materials audiences and interventions
- Communication approaches, channels and activities are strategically chosen
- Realistic evaluation indicators and methods are defined

What Is SBCC?



This [video](http://healthcommcapacity.org/hc3resources/what-is-sbcc/) explains SBCC in under four minutes: <http://healthcommcapacity.org/hc3resources/what-is-sbcc/>

You likely have seen or been involved in SBCC activities in your area, such as:

- A **mass media campaign** that promotes condom use to prevent HIV through public service announcements and/or serial dramas on radio or TV.
- A **theater group** performing a play about gender-based violence and holding a discussion afterward.
- A **radio talk show** that answers listeners' questions about family planning.
- A **school-based program** that encourages students to delay sexual debut.
- A **short message service (SMS) or hotline service** to provide information on family planning or HIV.

Effective SBCC programs use a variety of communication channels to reach the intended audiences.



Resources

For more information on all aspects of SBCC, the **Health COMPASS** (www.thehealthcompass.org) is a great place to start. The website includes everything from SBCC information and resources to actual tools and project examples from around the world.

HealthCOMPASS

Use Behavior Change Theory to Inform an SBCC Strategy

Behavior change theories can help us understand why people act the way they do and why and how behaviors change. SBCC theories can help guide SBCC program design and help you focus on what or who to address in your program.

Most behavior change theories include similar behavioral determinants, or factors that impact how or whether one thinks about a behavior (see **Table 2**⁴). Research around a health problem's root cause can help identify which determinant(s) most strongly influence a behavior among a particular audience, and therefore how to focus your program design. Once the specific behavioral determinants are identified, program messages and activities can be tailored to properly address them.



Reminder

When evaluating an SBCC activity or intervention, it is important to measure change in the behavioral determinants of interest, and not simply changes in knowledge and attitudes.

⁴ The content in this table is adapted from: Chapman, S., & Patel, D. (2004). PSI Behavior Change Framework "Bubbles": Proposed Revision. Washington, DC: Population Services International. Retrieved 11 April 2016 from <http://www.psi.org/publication/psi-behavior-change-framework-revision/>

Table 2. Common Behavior Change Theory Components

BEHAVIORAL DETERMINANT	EXPLANATION
<p>BEHAVIORAL DETERMINANTS RELATING TO: MOTIVATION <i>Motivation is an individual's desire to perform a promoted behavior.</i></p>	
Attitude	<p>An individual's⁶ evaluation or thoughts about the promoted behavior.</p> <p><i>For example: Whether a woman thinks using FP to delay or limit births and avoid AMA or HP pregnancies is "right" or "good."</i></p>
Belief	<p>An individual's perception about the promoted behavior, which may or may not be based on fact.</p> <p><i>For example: If an AMA or HP woman believes using an FP method will cause health problems.</i></p>
Intention	<p>An individual's future plan or desire to perform the promoted behavior.</p> <p><i>For example: If a pregnant woman plans to start using an FP method in a few months, after she gives birth, to prevent future pregnancy.</i></p>
Locus of Control	<p>The idea that an individual believes that his or her health is 1) under the control of other people or circumstances, such as fate or God, <u>or</u> 2) under the individual's direct control.</p> <p><i>For example: If a woman believes that God determines how many children she will have, she would not be motivated to use FP to avoid AMA or HP pregnancy.</i></p>
Outcome Expectations	<p>An individual's belief or trust that a promoted behavior will result in the promoted result.</p> <p><i>For example: If a woman believes that using a modern FP method will prevent an AMA or HP pregnancy.</i></p>
Subjective Norm	<p>This refers to whether an individual feels pressured to think about the promoted behavior the same way as others in his or her social group.</p> <p><i>For example: If an older women knows her family and friends support using FP to space births, she will be more likely to accept FP to space births.</i></p>
Threat (risk)	<p>If an individual feels at risk for a problem, he or she is likely to change his/her behavior to reduce the risk. "Threat" here is made up of perceived severity (seriousness of the problem) and perceived susceptibility (how likely they are to "contract" the health problem).</p> <p><i>For example: If a woman remembers her last delivery was difficult, thinks it is because she has had so many children already, and fears more births will be even harder and more dangerous, she will be more likely to adopt an FP method to prevent future pregnancies.</i></p>
Perceived "Cost" / Willingness to Pay	<p>An individual's belief of how much performing a behavior will "cost" them, and their readiness to "pay" this cost. Here, cost may be measured in time (away from work or family), price (monetary gain or loss), social acceptance (losing or gaining support from friends and family), or other factors.</p> <p><i>For example: If a woman thinks her family or community will ridicule or reject her for using FP, the negative social impact may be greater to her than the benefit of avoiding an AMA or HP pregnancy.</i></p>

⁵ Behavioral determinants are discussed in this table in terms of an individual, but sometimes the determinants may be considered in terms of a larger audience segment or community.

BEHAVIORAL DETERMINANTS RELATING TO: ABILITY

Ability refers to an individual's skills or capacity to perform a promoted behavior.

Knowledge	Correct information about the public health problem (symptoms, causes, prevention and transmission). <i>For example: If a woman knows and understands that being 35 or older or having five or more births makes future pregnancies risky, she has some correct knowledge about AMA and HP pregnancy.</i>
Self-Efficacy	An individual's belief that he or she is able to implement the promoted behavior successfully, and has the skills to do so <i>For example: Whether an AMA woman feels that she can discuss FP with her husband.</i>
Social Support	An individual's perception of how much support he or she will receive to perform the promoted behavior. An individual is more likely to perform a behavior that is supported by his or her social environment. <i>For example: If a woman's husband says he wants to help her avoid an HP pregnancy, and the woman's friends have encouraged her to use FP, she will be more likely to adopt an FP method.</i>

BEHAVIORAL DETERMINANTS RELATED TO: OPPORTUNITY

Opportunity refers to an individual's chance to perform a promoted behavior depending on environmental, institutional or structural factors.

Availability	Whether the necessary tools or products an individual needs to perform a behavior are accessible. <i>For example: If an HP woman wants to adopt and continue using a modern FP method, is the method available in her community?</i>
Quality of Care/ Trust in Services	Whether the necessary services an individual needs to perform a behavior are accessible. <i>For example: If an HP woman would like to learn about the risks of AMA and HP pregnancy, are her local service providers able and available to provide correct information and respectful counseling?</i>
Social Norm	A community-held belief about the promoted behavior that individuals are expected to follow. An individual is more likely to perform a promoted behavior if related positive and supportive social norms exist. <i>For example: If women in a community can make decisions about their own health, they are more likely to be able to control whether they can use FP.</i>

Annex A provides more information on the theories most commonly used in FP SBCC programs and examples of how they can be applied.



Resources

For step-by-step guidance on designing an SBCC strategy, please refer to HC3's **Designing a Social and Behavior Change Communication Strategy** Implementation Kit, located here: <http://sbccimplementationkits.org/courses/designing-a-social-and-behavior-change-communication-strategy/>

Section 4: Identify and Define Audiences

An “audience” is a group on whom SBCC efforts will focus. When you think of all the people you want to reach with your SBCC program, they fall into two groups: primary and influencing audiences. It is important to identify who you will be reaching in order to target your message to that individual. Your research findings should help you determine who your audiences should be.

Primary audiences are the key people to reach with messages, often because they are directly affected, directly involved or are the decision-makers for those who would benefit from a call to action.

Influencing audiences are those who can affect how primary audiences think about the specific behavior, shape social norms, influence policies or impact knowledge and behavior, either directly or indirectly.

Audiences may be segmented by demographic characteristics (such as sex, age, marital status, educational level, socioeconomic status, employment and/or residence) or by psychographic factors (such as values, opinions, attitudes or other lifestyle factors). For FP and MCH programs, audiences usually include women and couples of reproductive age (15 to 49 years), health facility staff or community distributors who provide FP or MCH services, and other community members and leaders who can influence behaviors, social norms and policy. As shown in the profiles, women might be just AMA, just HP, or both AMA and HP at once. It is important to acknowledge these differences so that program efforts reach women of various ages and parities and life stages as each of these groups may have different needs and circumstances. Postpartum and pregnant women are important sub-groups of all segments and might benefit from interventions tailored specifically to them.

Here are sample primary and influencing audience profiles for AMA- and HP-pregnancy prevention programming, including a few considerations.

Primary Audiences

Primary Audience 1: Women, 35 years-old, who have already had five births (AMA and HP, including postpartum and pregnant women)

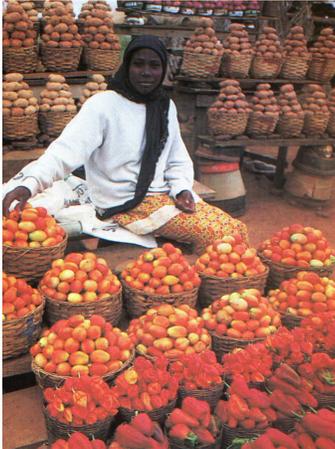


Photo Credit: © Shehu Danlami Salihu, courtesy of Photoshare

Audience Profile: Zalia is 35 years old and is the mother of five children. She is semi-literate and works as a fruit seller in small rural village. The nearest health center is five kilometers away and Zalia would go but it costs her CFA 600 for public transportation each way, besides the difficulty leaving her stall in the market. She is currently pregnant but does not want any more children after this one. She has never used family planning, but she's heard of the pill and condoms. She has never discussed family planning with her husband and is afraid to bring it up. Zalia and her husband are part of a very large extended family where decisions are made collectively, and she does not feel that she can make this decision on her own.

Consideration: Women who are in their mid-30s and women anticipating the birth of a fifth or higher child are the most at risk for future AMA and HP pregnancies if they continue to have children. You should consider your audience's specific life stage and AMA/HP pregnancy risk level carefully when designing program messages and activities to make sure that your program will truly have its intended impact.

Primary Audience 2: Women, less than 35 years old, anticipating a fifth pregnancy (HP but not AMA)



Photo credit: © 2006 Richard Nyberg, courtesy of Photoshare

Audience Profile: Mary is 28 years old and has four children. She grows vegetables and has a few small animals. She and her husband have never been to school and she does not know how to read. Her husband has a radio and they often listen for advice on crops and prices. During her last pregnancy she experienced maternal hypertension and knows that getting pregnant again might be dangerous for her. She is afraid to bring up birth spacing or limiting with her husband for fear he may look for another wife.

Consideration: Education levels and cultural norms, such as polygamy and religion, heavily impact how and whether a woman uses FP, and whether her husband supports this decision. Design program efforts based on the local reality, and make sure these details come through in your audience profile.

Primary Audience 3: Women, 35 years or older, who have not yet had five births (AMA but not HP)



Photo Credit: © 2015 Arturo Sanabria, Courtesy of Photoshare

Audience Profile: Florence is 37 years old, has a secondary school education and runs her own small shop in town selling food and household goods. She has three daughters. Florence and her husband do not particularly want more children, and Florence has used injectable contraceptives successfully since her last daughter’s birth. However, recently she has felt pressure from her mother-in-law to have another child – to try for a son. Florence can tell her husband is softening to the idea, too. Florence has heard having a child at her age can be dangerous, and worries about providing for another child. But her husband’s family is more traditional. They think a woman can easily continue to have children until menopause, and that a large family shows wealth and good fortune. She worries that if she loses her husband’s support to use FP, she will be forced to have another child.

Consideration: AMA women can feel pressure to have more children and programs need to provide additional support to ensure that she has a healthy pregnancy or consider reaching influencing audiences with messages to reduce making demands on AMA women to have more children.

Primary Audience 4: Women, less than 35 years old, who have not had five births (not yet AMA or HP)



Photo Credit: © 2010 Erika Lobe, Courtesy of Photoshare

Audience Profile: Beatrice is 24 years old and studying to be a pharmacist. She and her husband have agreed to delay starting their family until Beatrice has finished school and worked for a few years. They know that they want to have four children. They are satisfied users of modern family planning but have not really thought about how they will space their children once they start their family or how old Beatrice wants to be when she has her last child.

Consideration: Particularly in urban areas, women are delaying starting a family so they can reach personal, career or education goals before having a child. Younger women should be encouraged to think early on about how they will time and space their pregnancies in order to minimize especially AMA risks to themselves and their children.

Primary Audience 5: Providers of FP services



Photo credit: © 2008 Rachel Hoy, Courtesy of Photoshare

Provider Profile: Habiba is an older midwife who is well respected in her community, and is a real resource for the women in her community who need her care during childbirth. Men and women alike respect Habiba's importance in obtaining successful birth outcomes. Habiba has the same values as her community and has not entirely accepted that AMA and HP women need modern FP. Because her community believes in her, she sometimes does not admit to gaps in knowledge about FP methods, their effectiveness and the manageability of FP methods' side effects.

Consideration: Communities need clinical and non-clinical providers to help women and couples to successfully begin and continue to use FP methods to prevent AMA and HP pregnancies. Providers may be at risk of AMA or HP themselves and not aware of the consequences. Providers need to be trained to counsel couples on the risks of AMA and HP pregnancies, assist them in finding the FP method that is right for them, and provide advice and guidance if needs change or side effects occur, regardless of their personal beliefs.

Influencing Audiences

Influencing audiences for FP and MCH programs focused on AMA and HP pregnancies could include:

- **Male partners of women at or approaching HP or AMA** – A major barrier to FP use is women assuming their partners are against it. Messages directed at male partners encouraging them to discuss FP with their wives/partners, including the risks of AMA and HP pregnancies, and support their wife's FP choices will influence women's use and continuation of FP.
- **Friends and neighbors** – Peers provide a support network on which many women rely for advice and information. Women who are satisfied users of FP are also valuable for referring their friends to services.
- **Community and religious leaders** – Leaders have a great influence over FP decision-making. Especially as it relates to religion, it is important to make clear that Islam and Christianity support FP.
- **Journalists** – Where literacy levels are low, radio especially is one of the most used sources for news and information, including health information. As important information sources, radio and other media (e.g., TV, print) journalists producing stories on the benefits of FP for preventing AMA and HP pregnancies can encourage dialogue between couples and promote use of FP and MCH services.

Programs should be sure to develop profiles for influencing audiences they decide to address, similar to the profiles for primary audiences. These will help guide program planning and message development.

Section 5: Position AMA and HP and Develop Key Messages

Positioning

“Positioning” provides the overall emotional hook and direction for developing messages and determining persuasive and appealing communication approaches. Positioning provides direction for developing messages and helps determine the communication channels to be used. It also helps ensure that all program outputs and activities use a consistent voice, and reinforce each other for a cumulative effect. It is how communication professionals and marketers create a distinct impression of a product, service or behavior in the client’s mind. An intrauterine device (IUD), for example, could be positioned in terms of social status (including affluence or modernity), relationship satisfaction or health and well-being. Work with communication professionals or marketers to determine which will be most compelling to each audience.

Annex B provides illustrative positioning statements for FP SBCC programs focused on preventing the risks of AMA and HP pregnancies. Each emphasizes different motivators for FP use and highlights the primary benefits of FP as related to the positioning theme. Pretest and adapt these or other positioning statements to reflect local context.

Key Message Concepts

Outlined below are the types of key information about AMA and HP pregnancy to communicate to primary and influencing audiences. In developing key messages, add context-specific information and focus on locally relevant drivers and barriers to behavior change. Pretest messages with the intended audience and revise or refine messages according to audience feedback.

Depending on research findings, messages should include:

1. Risks of AMA and HP Pregnancy

- In many Sub-Saharan African contexts, pregnancy itself is seen as a high-risk situation. Often, a woman’s age or number of previous births are thought to increase health risks to the mother or child. Therefore, informing women, their partners and families about AMA and HP pregnancy risks and associated warning signs is an important first step in preventing these high-risk pregnancies.
- Messages can be developed for different audience segments: young women and their families who are anticipating their first pregnancy; women who have begun their family already and might be approaching AMA or HP status; and/or women who are already AMA and HP.
- AMA and HP pregnancy risk information can be discussed with an emphasis on preventing AMA and HP pregnancy through modern FP method use, but should also include a component on managing and monitoring risks for women who find themselves in AMA or HP pregnancy situations.

2. Benefits of Modern FP Methods

- FP can be viewed through several lenses. It can be seen as:
 - » An opportunity to build economic stability of families.

- » An avenue to secure birth spacing or limiting for the health of women.
- » A development tool, since families will be able to time and space pregnancies and maintain their productive lives by avoiding undesired pregnancy.
- With this framing in mind, messages can provide:
 - » Information about modern FP methods such as advantages, disadvantages, side effects and how to manage them, where to get methods and method costs.
 - » Information for partners and community leaders on advantages of using FP, focusing on FP health benefits for women at least 35 years old or approaching their fifth childbirth.
 - » The difference between the effectiveness of traditional or natural FP methods, and modern FP methods. There may be pervasive misconceptions about the effectiveness of natural methods such as withdrawal.

3. Importance of Supporting Women and Couples to Avoid High-Risk (including AMA and HP) Pregnancies

- While FP is seen as a woman's issue, in many communities it is the man who makes final FP decisions. Couple communication increases FP method use and empowers men and women to share decision-making.
- In much of Africa, community and religious leaders have an important role to play promoting health service use, couple communication and other behaviors. In addition to setting community norms, they can encourage more conservative community members to adapt healthier norms.
- Satisfied users are convincing service promoters. Community leaders should get familiar with local services so they can help promote FP and MCH service use. Messages can include satisfied users' stories to help create a supportive environment for women and couples to talk about and select FP methods that are right for them.
- Clinic- and community-based FP and MCH healthcare service providers must be prepared to discuss AMA and HP pregnancy risks with clients in a non-threatening way, and to help clients prevent or manage high-risk pregnancies, including with AMA and HP women.



Resources

For step-by-step guidance on pretesting SBCC materials, please refer to HC3's [How to Conduct a Pretest](http://www.thehealthcompass.org/how-to-guides/how-conduct-pretest) How-to Guide, located here: <http://www.thehealthcompass.org/how-to-guides/how-conduct-pretest>.

Section 6: Integrate and Implement

While it is possible to design a specific program focused on preventing AMA and HP pregnancy, integrating an AMA and HP communication strategy, messages and materials into broader FP and MCH programs is often more efficient and impactful.

In any FP or MCH communication program, it is essential to ensure that linkages with FP services are in place so that as demand for FP increases, clients can access services where they can receive high-quality counseling and an FP method of their choice.

Service delivery partners can address AMA and HP pregnancy by:

- Sharing global evidence and recommendations with national and local leaders (e.g., via presentations and factsheets). See **Annex L** for sample infographics.
- Including AMA and HP sessions in provider trainings, such as trainings on specific FP methods (e.g., long-acting reversible contraceptive methods/LARCs) or on FP counseling.
- Distributing posters and client take-home materials at service delivery points (e.g., clinics and pharmacies). See **Annex D** and **E** for sample client brochures.
- Offering supportive supervision (e.g., regular on-site teaching, feedback and follow-up) to healthcare providers on counseling women on AMA and HP.
- Working to ensure availability of a range of contraceptive methods, including LARCs.



Reminder

Program managers can also consider integrating AMA and HP messages and materials into non-FP programs, such as more general workplace health initiatives. Some examples on how to do this at the community level are described in **Annex F**, Guide for Working with Community-Based Groups.



Resources

Find more information about supportive supervision at:

- [Children's Vaccine Program at PATH. Guidelines for Implementing Supportive Supervision: A step-by-step guide with tools to support immunization. Seattle: PATH \(2003\).](http://www.path.org/vaccineresources/files/Guidelines_for_Supportive_Supervision.pdf)
- [No. 4 2002 Supplement to Population Report, Volume XXX, No. 4, Making Supervision Supportive and Sustainable: New Approaches to Old Problems. MAQ Paper.](https://www.k4health.org/sites/default/files/making%20supervision%20supportive%20and%20sustainable.pdf)

Program partners, such as other local organizations or government offices, can address AMA and HP pregnancy by:

- Sharing global evidence and recommendations with national and local leaders.
- Including AMA and HP key messages in general FP and MCH communication materials and activities.
- Developing interpersonal communication and counseling (IPC/C) approaches, preferably accompanied by provider materials and take-home materials for clients.
- Conducting community mobilization around AMA and HP risks and presenting FP as a solution.
- Creating characters and role models in radio and TV series with whom AMA and HP women can identify.
- Ensuring that at-risk women are targeted during recruitment into community-based activities.
- Distributing leaflets for women at community events and other opportunities.
- Conducting outreach to community and religious leaders to share information and tools about AMA and HP.
- Promoting referrals to providers sensitive to the unique needs of AMA and HP women.

Annex C provides more details on key AMA and HP communication activities and approaches.

A critical part of integrating HTSP content in an existing program is making sure relevant research questions and indicators are included in the program’s routine and special monitoring and evaluation (M&E) activities, for example:

- Including questions about AMA and HP in qualitative and quantitative research tools assessing FP knowledge, attitudes and practices.
- Disaggregating data by women’s maternal age at birth and by parity.

More information on M&E is included in **Section 9** of this I-Kit.

Selecting multiple channels for message delivery increases program impact.

Selecting appropriate communication channels – such as mass media (e.g., radio, TV, print), interpersonal communication (e.g., community outreach via community health workers) and information communication technology (e.g., SMS, social media) – to convey messages is critical to successfully reaching priority audiences. More information on communication approaches and activities can be found in **Annex C**.

Using several different communication channels and approaches creates a higher “dose” of exposure to the messages from a variety of credible sources. When the dose is high and from a variety of coordinated and harmonized sources, the audience response is also high. Achieving such a coordinated strategy is not easy, especially when a program involves multiple partners. However, the rewards are great – more women and couples become aware of AMA and HP pregnancy risks and are encouraged to seek FP services and more adopt modern FP methods.

Section 7: Develop an Action Plan

You may wish to use the following list of questions to plan your program's intervention for women at risk of AMA or HP pregnancy.

1. Review the data about women at risk for of AMA or HP pregnancies.

- What data do you have access to with information on AMA and HP pregnancies in your area?
- How can you gather additional information about AMA or HP directly from women at risk of AMA or HP?
- What are the key barriers in communicating with women at risk of AMA or HP pregnancies and their partners?
- What are the most difficult social barriers for women at risk of AMA or HP, or for couples to use FP?
- Is there political or social support to protect women from the risks of AMA or HP pregnancies?

2. Identify opportunities to integrate activities or messages for women at risk of AMA or HP into an existing FP program.

- Where are the opportunities to have contact with women at risk for AMA or HP and their partners?
- What services are already positioned to address risks of women at risk of AMA or HP?
- Who are the best messengers to communicate the risks of AMA or HP pregnancies?

3. Identify resources that can help integrate AMA or HP activities and messages into another existing program.

- Do you have a partner organization that would be able to help add this new focus to an existing program?
- Do you have resources from your program to repurpose for this particular purpose?
- What human and financial resources are available and when will they be available?

4. Identify activities that will reduce women's risk of AMA or HP pregnancies.

- What activities will you conduct with these available resources?
- What are the key messages that need to be communicated?
- What communication materials or other tools will you include in your activities?
- How will daily or seasonal activities, fluctuations or trends affect implementation?

5. Monitor program and audience feedback.

- How will you measure the success of your efforts to reduce AMA and HP pregnancies?
- How will you collect service statistics to understand whether the needs of women at risk of AMA or HP pregnancy are being met?
- How will you analyze this information and incorporate it into your future activities?

Section 8: Adapt Communication Tools

The I-Kit includes nine sample AMA and HP communication tools. Each provides a suggested template and format for communicating key messages on AMA and HP pregnancies to relevant audiences. FP or communication professionals can adapt the tools according to the program needs and particularly according to the local implementation context.

The nine tools are designed to reach community members at each level of the Socio-Ecological Approach.

Table 3 provides a breakdown of the tools by Socio-Ecological level. **Table 4** provides a description of each tool, who it is for and how to use it. The tools themselves are included in **Annex D** through **L**.

Table 3: Adaptable Communication Tool Overview

Socio-Ecological Level	Communication Tool
<p>Individual and Family & Peer Influences women’s knowledge and beliefs, as well as spouse and peer communication</p>	<ul style="list-style-type: none"> • Client brochure (for less conservative audiences) • Client brochure (for more conservative audiences)
<p>Community Influences collective efficacy and mobilization</p>	<ul style="list-style-type: none"> • Guide for Working with Community-Based Groups
<p>Social and Structural Influences services, media and policy</p>	<ul style="list-style-type: none"> • Counseling Guide for Providers • Counseling Guide for CHWs • Provider Reminder Poster • Guide for Researchers • Guide for Journalists • Infographics for Health Priority Decision-Makers

Table 4: Communication Tools Overview

Tool	
<p>Client Brochure (Less conservative audience version – Annex D – and More conservative audience version – Annex E)</p>	<p>What It Is: A pamphlet with key information on AMA and HP pregnancies and cues for behavior change. The pamphlets include an AMA and HP self-assessment and modern FP method information.</p> <p>Who It Is for:</p> <ul style="list-style-type: none"> • Women who are in their 30s or whose next birth would be their fifth – women at risk for AMA and HP. • Women who are just starting to plan their families, but may not be aware of AMA and HP pregnancy risks. <p>How to Use It: Give to/review with women during FP counseling sessions, at health service delivery sites and pharmacies, women’s group meetings, community-based events, CHW outreach activities, etc.</p>
<p>Guide for Working with Community-Based Groups (Annex F)</p>	<p>What It Is: A guide to develop AMA and HP community mobilization and peer-to-peer communication projects.</p> <p>Who It Is for: FP/RH/MCH/health organizations who want to engage health and non-health community groups in the effort to address AMA and HP pregnancy.</p> <p>How to Use It: Identify active community and work place groups and work with them to design, implement and monitor activities.</p>
<p>Counseling Guide (Provider version – Annex G; CHW version – Annex H)</p>	<p>What It Is: A tool to help structure conversations about AMA and HP pregnancy and FP method selection between providers and clients, starting with two simple questions: “Are you currently pregnant?” and “Do you or your partner want to have a child in the next 12 to 18 months?”</p> <p>The tool has two versions: A condensed version for CHWs, and a more detailed version for facility-based providers with more health training.</p> <p>Who It Is for: Facility and community-based FP and health service providers.</p> <p>How to Use It:</p> <ul style="list-style-type: none"> • Give to center- or community-based providers, supported by training on its use and content, to use with clients in their everyday work. • Providers and CHWs can use it in FP, pre- and post-natal, child health and home consultations
<p>Reminder Poster for Providers (Annex I)</p>	<p>What It Is: A tool to remind service providers to talk to clients about AMA and HP pregnancy risks. It summarizes the Provider/CHW Counseling Guide concepts in three main steps: Ask the client if and when she wants to become pregnant; Evaluate her situation; Respond to client questions, concerns and needs.</p> <p>Who It Is for: Facility-based FP and other service providers.</p> <p>How to Use It:</p> <ul style="list-style-type: none"> • Put the poster in counseling rooms where the provider can see it while speaking with clients. The provider can refer to the steps while counseling. • The poster can be used in FP clinics as well as prenatal, postpartum and child health services.

Tool	
Guide for Researchers (Annex J)	<p>What It Is: A set of focus group discussion and in-depth interview tools designed to collect primary data on AMA and HP knowledge, attitudes and perceptions. Questions included are for key groups, such as AMA/HP women, male partners, community leaders and others.</p> <p>Who It Is for: Program managers or researchers interested in finding out more about AMA and HP knowledge, attitudes and perceptions in their local area.</p> <p>How to Use It: The guide can be used to structure focus group discussions and in-depth interviews and may be adapted for different audiences.</p>
Guide for Journalists (Annex K)	<p>What It Is: A guide that outlines why and how journalists can address AMA and HP in their work and programs. It provides sample segment formats, key messages and basic information about AMA and HP.</p> <p>Who It Is for: Radio, print and television journalists.</p> <p>How to Use It:</p> <ul style="list-style-type: none"> • Provide to journalists, supported by training on its use, to use on their own and as part of an overall SBCC strategy. • Disseminate through Ministry of Health and Ministry of Communication channels.
Infographics for Health Priority Decision-Makers (Annex L)	<p>What It Is: A visual explanation of AMA and HP pregnancy, with one page dedicated to each. The infographics include key information about the health risks associated with AMA and HP pregnancies, other FP-related facts and a “call to action” in an easy-to-read and engaging format.</p> <p>Who It Is for: Decision-makers – such as FP service delivery managers, clinic heads, government officials, community and religious leaders – who need convincing that a focus on AMA and HP is the smart thing to do.</p> <p>How to Use It:</p> <ul style="list-style-type: none"> • The whole infographic or individual sections can be used in presentations, meetings and through social media channels. • It can be displayed as a poster for ongoing reminders, or can be printed as a handout for meetings. • Countries using it can adapt it by adding their data for comparison.

Suggestions for Adapting Tools

Before using these tools in your programs, it is important to test them with members of primary and influencing audiences to determine what to change to best meet their needs and the needs of the program. Changes might include⁶:

- Replacing some images (people, dress, buildings, symbols, etc.) with those that are more familiar to local audiences.
- Revising or adding messages that are more relevant to the local situation, gender norms or family planning priorities, being careful of how taboo topics – such as limiting pregnancies, religious factors or polygamous unions – are handled.
- Using the language and vocabulary used by local audiences.
- Organizing the information to be more easily understood by local audiences.



Resources

For more guidance on adapting SBCC materials, please refer to HC3's [How to Adapt SBCC Materials](http://www.thehealthcompass.org/how-to-guides/how-adapt-sbcc-materials) How-to Guide, located here: <http://www.thehealthcompass.org/how-to-guides/how-adapt-sbcc-materials>

Sharing Your Tools and Experiences

As programs work with and adapt these tools (and create others), they are encouraged to share their localized versions and experiences. This may be done by posting for discussion on [Springboard for Health Communication Professionals](http://www.healthcomspringboard.org) (www.healthcomspringboard.org) or on the [Health COMPass](http://www.thehealthcompass.org) (www.thehealthcompass.org).

⁶ When adapting materials, however, it is important not to change how AMA or HP are defined as these reflect international and medical standards.

Section 9: Monitor and Evaluate

Program managers rely on a variety of research methodologies and data sources for FP and MCH programs. All of these can be adapted or modified to address activities addressing AMA and HP pregnancies. For example, specific questions can be integrated into data collection tools. During analysis, data can be disaggregated by age and parity.

Specific indicators that assess the program’s effect on AMA and HP outcomes will be important to your program. **Table 5** below lists suggested FP communication program variables and corresponding indicators.

Table 5: Suggested Communication Variables and Indicators

Variables	Indicators
Knowledge	
Women at risk of AMA or HP ⁸ and their partners know about the risks of AMA and HP pregnancies.	<ul style="list-style-type: none"> Percent of women at risk of AMA or male partners who know the risks of having children at or after age 35. Percent of women at risk of HP or male partners who know the risks of having five or more births.
Service providers have knowledge of the risks of AMA and HP pregnancies.	<ul style="list-style-type: none"> Percent of service providers who know at least three adverse health outcomes associated with AMA or HP pregnancies.
Women at risk of AMA or HP and their partners have knowledge of FP methods.	<ul style="list-style-type: none"> Percent of women at risk of AMA or HP or male partners who know three or more modern FP methods. Percent of women at risk of AMA or HP or male partners who know where to get a modern FP method. Percent of women at risk of AMA or HP or male partners who know about FP method side effects and how to manage them.
Perceived Risk	
Women at risk of AMA or HP and their partners perceive themselves to be at risk of adverse health outcomes from AMA or HP pregnancies.	<ul style="list-style-type: none"> Percent of women at risk of AMA or HP or male partners who know at least three increased risks of AMA or HP pregnancies.
Beliefs	
Spacing and limiting pregnancies for women at risk of AMA or HP helps the mother and child stay healthy.	<ul style="list-style-type: none"> Percent of women at risk of AMA or HP or male partners who believe that spacing or limiting pregnancies helps the mother and child stay healthy.
Using FP will help a woman keep her figure and youthful looks. ⁹	<ul style="list-style-type: none"> Percent of women at risk of AMA or HP or male partners who believe that using modern FP methods will keep them looking beautiful.
Using FP will help a family face economic difficulties.	<ul style="list-style-type: none"> Percent of men and women who believe that using FP methods will help them face economic difficulties.

⁷ “Women at risk of AMA or HP” includes women approaching age 35 or are older, and women approaching their fifth birth.

⁸ A woman preserving her beauty and youth is included as an FP benefit in this I-Kit because these may be women’s/men’s priorities in some implementation contexts. Values that tie or limit a woman’s worth to her appearance are not ideal, but these themes are included here to represent a culturally appropriate way to begin the conversation about modern FP methods and, ultimately, protecting a woman’s health.

Attitudes	
Women should not have children at or after age 35.	<ul style="list-style-type: none"> Percent of women and men who believe women should not have children at or after age 35.
Couples agree to limit births to fewer than five per woman.	<ul style="list-style-type: none"> Percent of women and men who agree that fewer than five births per woman is sufficient.
Social influence/norms	
Perceived approval of FP for limiting births before a woman is 35 or before parity five.	<ul style="list-style-type: none"> Percent of women or men who believe that others in their community approve of FP use for women at risk of AMA or HP.
Perceived use of FP for limiting births before age 35 or before parity five.	<ul style="list-style-type: none"> Percent of women or men who believe that others in their community are using FP to limit births before age 35 or before parity five.
Interpersonal communication	
Women at risk of AMA or HP have ever discussed FP with partner.	<ul style="list-style-type: none"> Percent of women at risk of AMA or HP who discussed FP with their partner.
Women at risk of AMA or HP discussed FP with someone in past six months.	<ul style="list-style-type: none"> Percent of women at risk of AMA or HP who discussed FP with someone in the past six months.
Women at risk of AMA or HP discussed FP with a health worker in past six months.	<ul style="list-style-type: none"> Percent of women at risk of AMA or HP who discussed FP with a health worker in last six months.
Behaviors	
Women at risk of AMA or HP using a modern FP method.	<ul style="list-style-type: none"> Percent of women age 35 or older who currently use a modern FP method. Percent of women with five or more births who currently use a modern FP method.
Service providers counsel women at risk of AMA or HP and male partners on risks.	<ul style="list-style-type: none"> Percent of service providers who counsel women at risk of AMA or HP or male partners on the relevant risks.



Resources

For step-by-step guidance on developing a monitoring and evaluation plan, please see the HC3 guide **How to Develop a Monitoring and Evaluation Plan**, located here: <http://www.thehealthcompass.org/how-to-guides/how-develop-monitoring-and-evaluation-plan>

For more information on developing indicators, please see the HC3 guide **How to Develop Monitoring Indicators**, located here: <http://www.thehealthcompass.org/how-to-guides/how-develop-monitoring-indicators>

Closing Thoughts

Focusing part of your SBCC effort on reducing AMA and HP pregnancy can be a novel way to help women, their partners and their communities find value in modern contraception. It can be a way to break down barriers and begin a fruitful dialogue on improving family health and welfare by making conscious decisions about the number and timing of pregnancies. In developing and implementing your SBCC strategy, remember to make sure that:

- The motivations and concerns of both primary and important influencing audiences are taken into account
- All statistics used are relevant to your audience and environment and are up to date
- Images or photographs will be understood and recognized by your audiences (by pretesting them before printing)
- Addressing difficult topics (such as limiting births) is balanced with providing information that is important and relevant to your audiences
- Culture and religion are respected
- Messages are consistent and credible
- Language is appropriate for your audiences
- A variety of complementary communication approaches are used

We wish you the best in this effort and, as mentioned earlier, we invite you to share your tools and experiences on **Springboard** (www.healthcomspringboard.org) or on the **HealthCOMpass** (www.thehealthcompass.org)!