Life Saving Commodities
Improving access, saving lives

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

AN ADAPTABLE COMMUNICATION STRATEGY FOR EMERGENCY CONTRACEPTIVE PILLS

JULY 2014

WE SUPPORT EVERY WOMAN EVERY CHILD

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HEALTH COMMUNICATION CAPACITY COLLABORATIVE

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Acronyms

CBO	Community-based organization
CCP	Johns Hopkins Center for Communication Programs
CHW	Community health worker
DHS	Demographic and Health Surveys
ECP	Emergency contraceptive pill
EWEC	Every Woman Every Child
GBV	Gender-based violence
HC3	Health Communication Capacity Collaborative
ICT	Information and communication technology
IPC	Interpersonal communication
IUD	Intrauterine device
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PPP	Public-private partnership
RMNCH	Reproductive, maternal, newborn and child health
SBCC	Social and behavior change communication
SM	Social marketing
SMS	Short message service
STI	Sexually transmitted infection
UN	United Nations
UNCoLSC	United Nations Commission on Lifesaving Commodities for Women and Children
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization
WRA	Women of reproductive age

Introduction

Aim

To provide step-by-step guidance and illustrative content in creating a communication strategy to generate demand for **emergency contraceptive pills (ECPs)**.

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, Life Saving Commodities (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 SM 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 United Nations Commission on Lifesaving Commodities (UNCoLSC) for Women and Children (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.

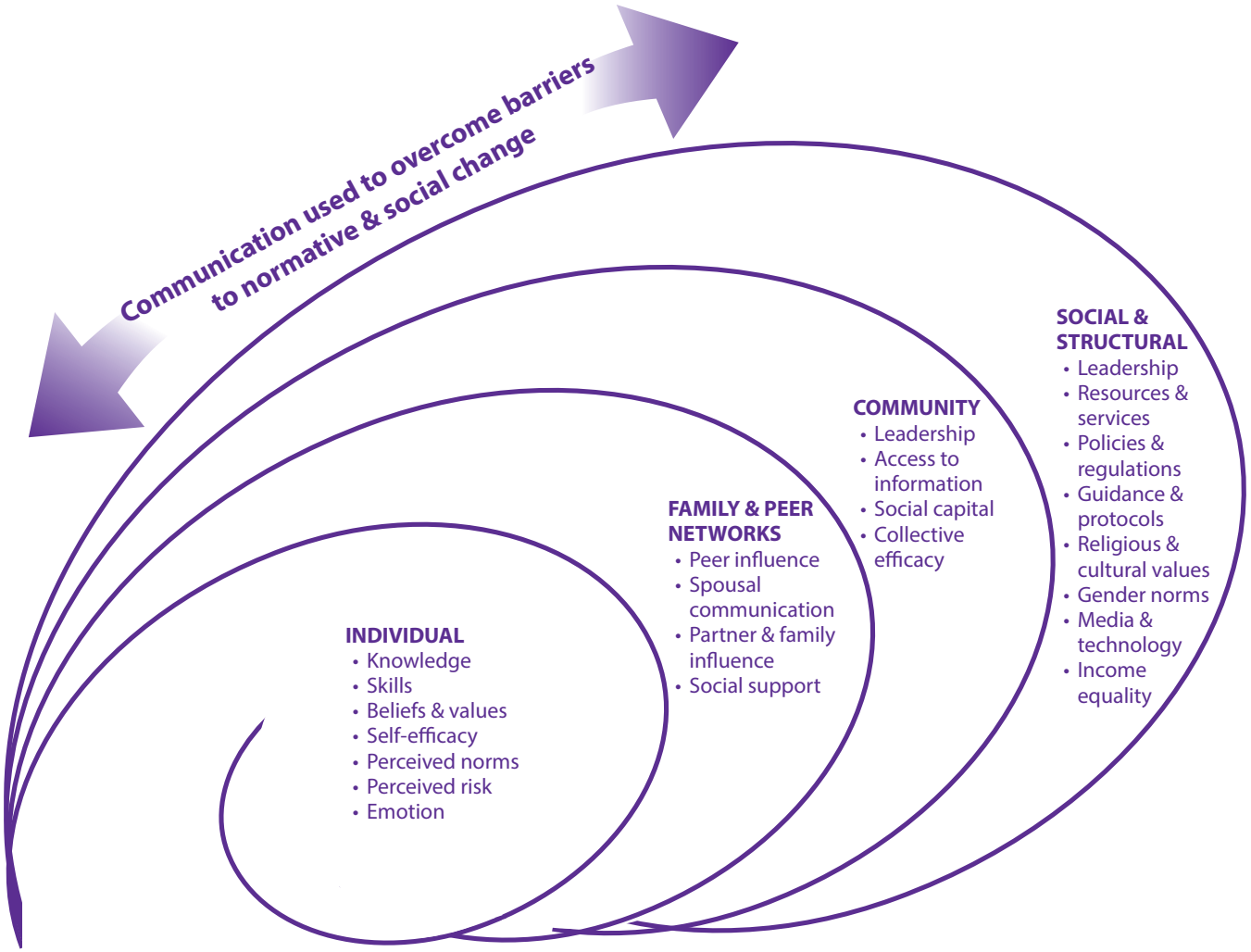
Information and Communication Technologies (ICTs). ICTs refer to electronic and digital technologies that enable communication and promote the interactive exchange of information. ICTs are a type of media, which include mobile and smart phones, short message service (SMS) and social media, such as Facebook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

- What is the contraceptive prevalence rate?
- What is the contraceptive method mix?
- What is the unmet need for contraception?
- How many pregnancies are unintended?
- How many pregnancies result in abortions or unwanted births?
- How many abortions occurring in the country are (estimated to be) unsafe?
- How many pregnancies result from contraceptive failure?
- What are the sociodemographic characteristics of women with unintended pregnancies?
- What are the sociodemographics of the young population (15–24) and what contraceptive method(s) do they mostly use?
- Are emergency contraceptives registered in country? What brands (formulation, packaging)? Which, if any, are on the Essential Medicines List? If not registered, what is the registration process—e.g., time, requirements?
- Is there a regional or local manufacturer?
- What regulations or policies govern supply, distribution and availability? How may these affect demand?
- How is ECP procurement being funded?
- What is the price of ECPs in the private and public sector? What are the costs of services associated with counseling and administering ECPs?
- What is the availability of ECPs by region/district?
- What patterns exist in uptake of ECPs over the past 5 to 10 years (increased, declined, remained static)?
- What is the number of private sector vs. public sector clinics offering ECPs by region/district?
- What level of provider (doctor, nurse, midwife, etc.) is permitted to prescribe, administer and/or counsel on ECPs?

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 women has used ECPs?
- What proportion of providers, women, men and other audiences is aware of ECPs?
- What proportion of providers, women, men and other audiences has accurate knowledge about ECPs?
- What are the perceived benefits of using ECPs by providers, women, their partners and other

influencing audiences?
- What are the perceived barriers to accessing and using ECPs for providers, women and their partners?
- Are there common misconceptions or misinformation about ECPs?

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?
- What is the incidence of gender-based violence (GBV) in the country? Are there specific areas with social unrest that may increase likelihood of GBV and rape? What kind of support is available to those who experience GBV? Is post-violence counseling offered to victims of sexual violence? Does it cover the use of ECPs?
- Under what circumstances is it acceptable to use ECPs? Under what circumstances is it not acceptable?
- How does the level of income affect use of ECPs? Do poorer women and couples have access to both information and product?
- Are there regulations in place that limit access to ECPs for specific populations?
- Who are the stakeholders, key players and gatekeepers who impact or influence demand and utilization of ECPs?
- How are these stakeholders, key players and gatekeepers influencing demand and utilization of ECPs?

Service Provision
- Are clinical and counseling guidelines available at all levels of the health system?
- Are protections in place in national counseling guidelines to ensure informed and voluntary decision making related to ECPs?
- Do counseling guidelines ensure adequate information on ECPs, including side effects and use?
- Do pre-service and in-service curriculum materials cover ECPs adequately?
- Do providers share accurate and appropriate information about the product with their clients, including with adolescents and unmarried women?
- Do providers offer ECPs as part of a range of available contraceptive options with their clients, including with adolescents and unmarried women?
- What are the main challenges for providers regarding provision of ECPs? What are typical concerns that providers may have regarding the provision of ECPs?
- Are ECPs systematically available in crisis settings? Are crisis workers trained to provide it?
- What are the perceived barriers and benefits to accessing ECPs services in the private versus public sector?
- Do providers have adequate skills to counsel, prescribe and/or administer ECPs?
- How integrated are ECPs with other family planning programs?

Media and Communication
- Do couples communicate about using ECPs or other contraceptive methods?
- 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 emergency contraception and demand for ECPs?
- What communication materials and programs already exist related to ECPs?
- 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 ECPs 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 below.

	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 a secondary 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 target group rather than just a secondary audience becomes a Strategic Priority.
Example for ECPs:		
In a 2011 study, the proportion of pregnancies that are mistimed or unwanted across 20 sub-Saharan Africa countries was between 5 percent and 30 percent between 2002 and 2011. Thirty-four percent of all pregnancies in these countries ended in an unintended birth or an induced abortion. One in three unintended births was from contraceptive failure.	There is a high unmet need for contraception and some women are at higher risk of unintended pregnancy than others. These women include young unmarried women and adolescents, women at risk of domestic- and gender-based violence, women using condoms or traditional methods as their main contraceptive method, and women in unstable or crisis situations.	Presenting ECPs as a back-up plan for preventing unwanted pregnancies from taking place after sex and avoiding an abortion becomes a strategic priority. Very specific end user audiences should be made priorities for ECPs, according not only to age group, but also domestic or living situations.

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 emergency contraceptive pills is:

Women of reproductive age, including adolescents, are aware of, informed about and able to access ECPs easily when they need them, where they need them and at a price they can afford - in case of method failure, unprotected sex or sexual assault.

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 below can be helpful.

	Primary Audience Influenced	Estimated Power of Influence (Low, Moderate, Strong)	Attitude Toward Use of ECPs 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, and 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 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.
- Pretested 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 that have an impact on demand or could be utilized to improve efficiency. The following are examples of potential areas for linkages when designing a demand generation program for ECPs:

- Other family planning programs that do not currently include ECPs 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.
- Existing portfolio of services provided and channels used by non-clinical providers.
- Post-rape counseling and care—including police force, hospital emergency rooms, refugee camps and crisis programs.
- Adolescent health programs.
- 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, security, 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

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, business cards, enrollment forms and attendance sheets, as well as records tracking product provision and distribution).
- 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 emergency contraception).
- 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 ECP, 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 community health sessions conducted on ECP with women of reproductive age.	Example: Proportion of women of reproductive age who report that they know where to access ECPs.	Example: Proportion of women of reproductive age who use ECPs.	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 a 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 mother who has experienced a loss of a newborn may be more or less likely to respond to a survey about practices in newborn care.
- *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 Emergency Contraceptive Pills

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 and STI/HIV infection. 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 (PRB, 2012). Although globally contraceptive use has steadily increased in the past three decades, use in some of the poorest areas of the world, such as sub-Saharan Africa, remains low. It is estimated that less than one-fifth of couples in sub-Saharan Africa are using contraception (PRB, 2012). There is global consensus that contraception has direct and indirect influences on a number of health outcomes, including maternal, neonatal, and infant health and community health (Kerber, 2007; Ronsman & Graham, 2007).

Across 20 countries analyzed between 2002 and 2011, the proportion of pregnancies that were mistimed or unwanted was between 5 percent and 30 percent (Bradley, Croft, & Rutstein, 2011). The countries studied represented sub-Saharan Africa, Asia, the Middle East, Europe and Eurasia, Latin America and the Caribbean. Thirty-four percent of all pregnancies in these countries ended in an unintended birth or an induced abortion. One in three unintended births was from contraceptive failure.

Some women are at higher risk of unintended pregnancy than others, including young unmarried women and adolescents, women at risk of domestic and gender-based violence, and women using condoms or traditional methods as their main contraceptive method. Many unplanned pregnancies occur within a year after first sexual intercourse. Studies have found a delay of about one year on average between starting sexual activities and first use of modern contraceptives. Adolescents struggle with condom negotiation and many young women report that their first sex experience was coerced.

In addition, women living in unstable or conflict settings are at high risk of unwanted pregnancies; yet in refugee camps and other settings, ECPs are not provided in a consistent manner for unwanted pregnancies, including to survivors of sexual violence.

While most public health efforts are focused on encouraging men and women to use a regular contraceptive method, it is also important to offer a "back-up" or "last-minute" method in case a regular method fails or no method was used (regardless of whether sex was consensual or forced). Offering an option to women who have had unprotected consensual or forced sex is a public health priority that addresses the risk of unintended pregnancies, which in turn can lead to abortion, child neglect or abandonment.

Commodity Context

Emergency contraception is an important component of a comprehensive family planning program. It offers a reliable option to address the needs of the populations most at risk of unintended pregnancies. Depending on the formulation used and timing of use, ECPs can reduce a woman's risk of becoming pregnant —between 75 and 89 percent— from a single act of intercourse (ICEC & FIGO, 2011).

While several products can be used as emergency contraception , the levonorgestrel-alone ECP is the only one that is widely available in developing countries. It commonly consists of a packet containing two tablets of 0.75 mg each, labeled to be taken 12 hours apart. Recent research has shown, however, that the full dose of 1.5 mg can also be taken at once and does not cause more side effects than two 0.75 mg doses 12 hours apart. ECPs can be used up to five days after unprotected sex, but are generally more effective the sooner they are used.

Extensive research on how ECPs work suggests that interference with ovulation is the primary, and possibly, only mechanism of action. ECPs do not have any effect after fertilization, cannot terminate or interrupt an established pregnancy, and will not stop a fertilized egg from implanting in the uterus. They have not been shown to harm a developing embryo.

ECPs are safe and appropriate for dispensing by a pharmacist or drug seller without a prescription. Additionally, they are available directly from pharmacists informally even in many developing countries where they are registered as a prescription product. Dedicated ECPs are available from over 90 different manufacturers and can be purchased at central level (i.e. by central procurement agencies) for as low as US $1 per pack depending on quantities ordered. Packs typically contain one complete "dose," consisting of one or two pills, depending on the brand and formulation.

There are more than 100 ECP brands used around the world and the most common types include Postinor®, Pregnon®, NorLevo® and Escapelle®. More information on ECPs brands, types and manufacturers is available on the International Consortium for Emergency Contraception (ICEC) website at: http://www.cecinfo.org/country-by-country-information/status-availability-database/ec-pill-types-and-countries-of-availability-by-brand.

Audience and Communication Analysis

Access to ECPs varies across different country contexts and is influenced by a number of cultural, social and political elements. A recent global synthesis of existing demand creation evidence for ECPs found that there are three significant barriers to address in order to increase provision of ECPs: low awareness, knowledge and acceptability at individual, community and societal levels; provider knowledge and skills; and provider bias and negative attitudes (HC3, 2013).

Low Awareness, Knowledge and Acceptability at Individual, Community and Societal Levels

DHS data show that the percentage of women who have heard about ECPs as a contraceptive option is considerably lower than for other modern family planning methods. Women's awareness of ECPs continues to be below 10 percent in Senegal and Zambia; and across the globe, knowledge of ECPs is only around 20 percent (ICEC & FIGO, 2011). Even in countries like Kenya, where the method is better known—56 percent of women report having heard about ECPs—usage remains low. Among those who have heard of it, misconceptions remain. A study in Kenya found that among those who knew about the method, one-third believed that it causes abortion and only about two-thirds knew the correct timeframe for using the method (Population Council & PSI Kenya, 2009). This indicates the need for continued education and awareness creation on ECPs across a number of settings.

Provider Knowledge and Skills

There is a great variability of knowledge levels among providers around the world. Responses collected through an extensive literature review (Williams, 2011), showed a range in knowledge—from 34 percent

of urban Ghanaian physicians to 90 percent or more of providers in Turkey (Sevil, Yanikkerem, & Hatipoglu, 2006), Indonesia (Syahlul & Amir, 2005), Barbados, and Jamaica (Yam et al., 2007). Two studies in Nigeria (Ebuehi, Ebuehi, & Inem, 2006; Oriji, & Omietimi, 2011) also show substantial variability among doctors, nurses and other health care providers regarding correct knowledge of administration of ECPs and the biological mechanism of action.

In Mexico, a study showed significant pharmacist confusion between ECPs and mifepristone, the abortion pill (Mané, Brady, RamaRao, & Mbow, 2012). In Bangladesh, as many as 54 percent of providers incorrectly classified ECPs as a product that can cause abortion before they participated in training (Khan, Shaikh, Hossain, Mir, & Rob, 2008). This misunderstanding was also prevalent among a smaller proportion of providers in Turkey, Ghana and Nigeria (Ebuehi et al., 2006; Steiner, Raymond, Attafuah, & Hays, 2000; Uzuner et al., 2005). Forty-two percent of providers interviewed in Pakistan were "unsure" whether ECPs could cause abortion or not (Abdulghani, Karim, & Irfan, 2009). These findings are also similar among many opinion leaders, religious leaders and government officials; even in developed countries like the United States, ECPs are still confused with mifepristone.

A study from Kenya and Ethiopia also found that although provider knowledge of ECPs—as an option to prevent pregnancy after unprotected sex—was high, knowledge about the actual biological mechanism was low, leading to confusion on how to administer them (Judge et al., 2011). A 2007 study from Uganda found that the majority of health care providers surveyed knew about ECPs and generally had favorable impressions, but many had outdated or inadequate clinical information (Byamugisha et al., 2007). These knowledge gaps affect the providers' comfort and ability to properly counsel potential ECP clients.

Provider Bias and Negative Attitudes

Barriers related to provider attitudes and beliefs, if addressed, could increase access to and coverage of ECPs. For example, in Ethiopia, a study found evidence of bias among pharmacists concerning the administration of ECPs to certain populations, such as adolescents and unmarried women, and concerns over repeat use (Gold, 2011). For example, there is widespread belief among providers and women that repeat use will cause long term health problems, especially related to fertility, despite evidence that suggests no increased risk (Halpern et al., 2011).

Pharmacists in several countries report not being willing to stock ECPs because they believe it causes abortion, increases promiscuity or discourages clients from using a barrier method.

Other aspects influencing availability and use of ECPs include:

- Type and number of products registered and distributed in the country (choice).
- Price levels and availability (is there a public sector offer or a socially marketed product or only commercial products).
- Inclusion of ECPs in national family planning programs, including essential medicine lists, policies and distribution systems.
- Status of ECPs (prescription vs. over-the-counter).
- Policy restrictions on age (who can access ECPs).
- Number and reach of outlets providing ECPs (clinics and pharmacies).

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 of reproductive age, women at high risk of GBV)	Each year there are an estimated 86 million unintended pregnancies worldwide, 41 million of which end in induced abortion. In addition, women living in unstable settings are at high risk of unwanted pregnancies. In 2007, 54 percent of women that survived rape in refugee camps in seven countries did not receive ECPs within 120 hours of an incident.	Limited availability of ECPs. Limited awareness and promotion. Fear of side effects, including causes abortion, infertility or menstrual changes.	Offers a reliable option to address the needs of the populations most at risk of unintended pregnancies.
Providers (public and private, pharmacy, clinic- and community-based)	Low levels of promotion and administration/prescription of ECPs.	Low levels of knowledge of ECPs regarding biological mechanism and side effects. Unwillingness to stock/prescribe ECPs because of association with abortion. Low confidence levels of prescribing/ administering ECPs. Provider bias – provides ECPs only to certain populations.	Method easily incorporated into current family planning counseling. Commodity produced by over 90 different manufacturers – feasible availability.

Step 2: Define a Vision

Refer to page 19 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 of reproductive age, including adolescents, are aware of, informed about and able to access ECPs easily when they need them, where they need them and at a price they can afford—in case of method failure, unprotected sex or sexual assault.

Step 3: Choose the Intended Audiences

Refer to page 20 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)

The proposed audiences are illustrative of existing intended audiences in several countries and typical situations where ECPs would be the best option. However, it is highly recommended that each country conduct additional research to identify the most relevant profiles for its own context. It is also important to understand that the need for ECPs is most likely driven by behaviors, rather than by socio-demographic attributes. Therefore, when defining an intended audience, it is important to take into account not only key socio-demographics, such as age, place of residence (urban, rural) and relationship status (single, married, divorced), but also situations, such as the partner's location (at home or not), the desire for children (delaying, spacing, limiting), the period of life (transition into marriage, out of marriage, becoming a widow), the risk of sexual or intimate partner violence, and the type of setting (e.g., crisis).

Although health system officials and decision makers are potentially important influencing audiences, they are not included in this communication strategy, as key messages for advocacy on ECPs are found in *Scaling Up Lifesaving Commodities for Women, Children and Newborns: An Advocacy Toolkit,* which 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.

Primary Audiences

- *Primary audience 1: Women of reproductive age (with sub-audiences—e.g., by life-stage or age, parity, and/or location)*
    - *Sub-audience 1a:* Unmarried adolescent girls (15–19 years) – Many adolescent girls are hoping to finish secondary school and further their education. At the same time, they are also becoming sexually active, but are not necessarily well informed about their contraceptive options. As a result, many of them become pregnant and drop out of school.
    - *Sub-audience 1b:* Women not using a contraceptive method or having experienced method failure. This group includes women older than the adolescent group, married or unmarried, who are at risk of pregnancy due to not using a contraceptive method or experiencing method failure.
    - *Sub-audience 1c:* Women at risk of sexual and/or intimate partner violence, and those living in humanitarian crisis settings—this group would include primarily women at risk of being raped—e.g., those in crisis settings or in areas with a high rate of sexual violence.
- *Primary audience 2: Pharmacists and pharmaceutical counter staff*—Pharmacy staff include the pharmacist in charge of the outlet, as well as staff working behind the counter. Depending on their background, their knowledge about ECPs may be very basic or non-existent. In most cases, pharmacy staff need to be better informed about the product and its mode of action. They also need to learn strategies to counsel clients adequately and without bias.
- *Primary audience 3: Clinical providers (public and private)*—Clinical provider bias and lack of knowledge on ECPs have been identified as key barriers to increased uptake of ECPs.
- *Primary audience 4: Community health workers (CHWs) or distributors (public and private)*—The non-clinical provider is a frontline worker based at the community level, often in the same community in which she lives. As the primary point of information—and sometimes also primary point of distribution—for remote

communities, CHWs need to not only have accurate knowledge about ECPs and their mode of action, but also know where to access ECPs, so that they can adequately counsel women in need.

- *Primary audience 5: Responders to gender-based violence, including those in crisis settings*—Police officers or refugee camp workers are the primary point of contact for women who have been victims of sexual violence, and as such, they need to have knowledge of ECPs, and be able to either administer or refer to appropriate services.

Influencing Audiences

- *Influencing audience 1: Male partners and friends*—Male partners can have significant influence, positive and negative, on their female partners when it comes to accessing ECPs. Similarly, friends can influence a woman's choice of using ECPs.

Audience Profiles

Primary Audience 1: Women of Reproductive Age

Sub-audience 1a: Unmarried adolescent girl

Malita, 17, unmarried adolescent girl living in Kabala, Sierra Leone

Malita is a young girl, aged 17, who lives with family members in Kabala, Sierra Leone. She is attending the local secondary school and is hoping to stay enrolled. Her hopes for life are to better herself through continuing her education or learning a trade. She is beginning to have sexual relationships occasionally, though sometimes unwillingly, with boys her age and also older men. She does not want to go to a health clinic to get information on family planning methods because her friends have had negative experiences or poor treatment by clinic staff. Malita has heard about HIV, but is more worried about getting pregnant as it might mean dropping out of school. She does not feel comfortable negotiating condom use with partners and thinks just mentioning it to a man will make him break off the relationship.

Sub-audience 1b: Women not using a contraceptive method or having experienced method failure

Mary, 36, divorced mother living in Kalangala District, Uganda

Mary is in her mid-thirties and divorced. She lives in an urban area, with her children and her young sister, who helps around the house. She is a working professional, with advanced education and high economic status. She is a typical "early" adopter of new technologies and rather independent in her choices. She has a partner, at times, but does not live with him, and tends to have sex only occasionally. She usually uses condoms as her preferred method to protect herself against STIs and pregnancy, but at times, she and her partner forget. There have also been times when the condom has broken. She does not see the need to use an additional contraceptive method since she has infrequent sex. She has heard of ECPs, but believes it can end an already established pregnancy so is against using such measures.

Sub-audience 1c: Women at risk of sexual violence, including intimate partner violence and those living in humanitarian crisis settings

Lucia, 24, mother living in Mizimba District, Malawi

Lucia lives in a low-income household where every day is a struggle. She has four children and does not want more because she does not have enough resources to take care of them. Her husband does not have a stable employment (he has to find some work every day) and Lucia is doing small jobs (growing and selling vegetables or fruits) to gather additional income. Her husband tends to drink and comes home very late once or twice per week wanting to have sex and then falls asleep. He will get angry and violent if something does not go his way and sometimes hits her. He never wants to talk about money and Lucia is afraid he will get upset if she even tries to discuss using some of their sparse income to go to the health clinic for a family planning consultation. Lucia is a good candidate for a contraceptive method such as injectables, but she finds it difficult to attend the family planning clinics without her husband finding out and is afraid he will beat her if she goes without his permission.

Sub-audience 1c: Women at risk of sexual violence, including intimate partner violence and those living in humanitarian crisis settings

Sarifina, 30, mother living in Kissidougou Refugee Camp in Guinea

Sarifina lives in a refugee camp in Guinea. She had to flee her home due to political instability and high rates of violence. She is in the camp with her three children and is waiting for the political unrest to subside before heading back home. She is at risk of gender-based violence, including rape from people leaving nearby—relatives, soldiers or men in the camp. She does not currently use a contraceptive method since she does not have regular access to family planning services.

Primary Audience 2: Pharmacists and Pharmaceutical Counter Staff

Issa, 29, manager of a local pharmacy in Bamako, Mali

Issa is in charge at a local pharmacy in Bamako and helps clients with their requests. He has a diploma in pharmaceutical technical assistance (which is less comprehensive than a pharmaceutical degree) and has been hired by the pharmacy owner to manage the outlet. He reports to the owner and involves him in decision making when necessary, but on a daily basis, he is the main point of contact for clients. He only has basic information about contraceptive methods and is not formally trained about ECPs. He has occasional demand for this product, which typically comes from young women in their 20s who may not feel comfortable going to clinics. Sometimes he tries to convince clients to avoid repeat use. He also lacks the time and space to counsel the client in private and has no formal training and little motivation to encourage the use of other family planning methods.

Primary Audience 3: 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 will 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 with the information they need to make the choices best for them. She is familiar with common family planning methods, but not as much with ECPs. She is not sure that ECPs are allowed in her country, because many people think it causes abortion. She is not very confident about the dosage and timing for use so she would hesitate to mention it to a client. She thinks ECPs are used by promiscuous people, so if someone comes asking for ECPs, she may not be very friendly or open about it. She is not sure how safe ECPs are and whether there are any long-term side effects.

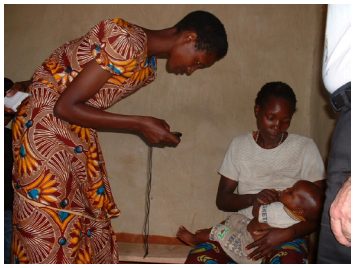
Primary Audience 4: Community Health Workers or Distributors

Susan, 28, community health worker in the peri-urban neighborhoods of Kampala, Uganda

Susan has developed strong peer-to-peer relationships with women in her area, which are built on trust and mutual understanding. Because of these strong relationships, she is able to communicate openly with her peers and community. In addition, Susan is often the first person in her area to be approached with questions about family planning. She 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. She is able to distribute oral contraceptives and condoms, as well as ECPs. 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 ECPs, especially younger women or women she believes should not be having sex. She also faces resistance and embarrassment because she is so well known to community members and embarrassed to talk about issues that may seem much too personal. These beliefs can sometimes get in the way of providing appropriate unbiased information. She is open to learning more about family planning methods and gaining more skills, given the opportunity.

Primary Audience 5: Responders to Gender-Based Violence, Including Those in Crisis Settings

Officer Okafor, 39, police officer in Lagos, Nigeria
Officer Okafor is a man in his late thirties. He works at the local police office in Lagos, Nigeria. He deals with robberies and petty crimes, and was recently trained on guidelines for handling sexual assault complaints. In his neighborhood, it is not uncommon for women—especially young ones—to be assaulted at night by strangers. Women usually show up at the police office a few hours after being attacked or are brought by relatives or family members after being found. Per his training, he takes their deposition and gives the victims information on medical services they should seek for further assistance, but often doubts the validity of the woman's story and does not think about the potential risks for HIV and unintended pregnancy.



Sonia, 28, refugee camp worker in Kiziba, Rwanda
Sonia is a young woman in her late twenties. She works as a reproductive health advisor in a refugee camp in Kiziba, Rwanda. In her camp, she sees many women and children who had to flee their homes due to local armed conflicts. Some of these women were raped prior to arriving to the camp and are also at risk of rape within the camp itself. While Sonia is not able to ensure their protection at all times, she wants to make sure that she has access to all tools and supplies for them to avoid unwanted pregnancies and HIV.

Influencing Audience 1: Supportive Male Partners and Friends

Sanjeev, 27, male partner of a breastfeeding mother, living near Pune, India
Sanjeev lives in the outskirts of Pune, India. He is in a stable relationship and is supportive of his partner using a contraceptive method of her choice. At the present time, his partner is not taking a regular method because she is breastfeeding a young baby and he is concerned that she might become pregnant. He is willing to use condoms, but in case the method fails, he wants to make sure his partner gets access to another contraceptive option such as ECPs.

Winnie, 22, young mother living in Esabalu, Kenya
Winnie lives in Esabalu, Kenya. When she was 16 years old, she had an unintended pregnancy and became a single mother. She had to drop out of school and now feels her options for education, and for life in general, are limited. She wants to make sure that young girls like her do not go through the same ordeal and is interested in being trained on key family planning messages so she can help girls in her community.

Step 4: Design Message Strategy

Refer to page 21 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 to 49 years) in the intended audience who:

1. Know about ECPs, when to take them and how they work.
2. Know where to access ECPs when needed.
3. Feel confident and motivated to use ECPs when needed.
4. Talk to providers or friends about ECPs.
5. Report using ECPs if/when needed.

Positioning

Peace of mind is a possible positioning concept for ECPs for all segments of women. This positioning was used in Kenya for a generic ECPs campaign: the Swahili word "tulia" translates into "relax." ECPs can be positioned as providing a back-up option that gives a second chance to women who have had a problem with their contraceptive method or did not have the option to use one.

Other key positioning possibilities are:

- Preparation—in case you have unprotected sex.
- Responsibility—when your method has failed you (used in PSI India and DKT Ethiopia).
- Control—get pregnant when you want.

Key Promise

When your contraceptive method fails or you have unprotected sex, do not worry, ECPs can provide a second opportunity to avoid an unwanted pregnancy.

Support Statement

ECPs are contraceptive pills that can be taken up to five days after unprotected sex to reduce your chances of getting pregnant. They are very safe and have no long-term risks or side effects.

Key Messages

Key messages for ECPs should focus on the benefit, safety and mode of action of ECPs. Key information should also be provided in a simple, easy-to-understand and non-threatening way, including information about possible side effects and success rate of ECPs. Messages addressing the fact that women often underestimate their chances of getting pregnant would also help increase perceptions of "risk" and, in turn, increase the use of ECPs. In some countries, it may also be appropriate to add messaging around HIV testing and counseling for women who had unprotected sex.

Basic messages about ECPs should be shared with all sub-audiences.

- ECPs consist of two pills that you take after unprotected sex if you do not want to become pregnant.
- ECPs are most effective when taken immediately after unprotected sex, but they can be effective up to five days after unprotected sex.
- ECPs are safe and have very limited side effects which are temporary and will disappear after use.
- Repeat ECPs use has no long-term impact on health or fertility.

Key Messages (continued)

- ECPs cannot disrupt an existing pregnancy. You can only use them to prevent a pregnancy from happening.
- ECPs are a back-up option and should not be used instead of a regular contraceptive method.
- ECPs do not protect against HIV and other STIs. Always use a condom to prevent HIV and other STIs.

In line with the "peace of mind" positioning, key messages for women of child-bearing age may be further segmented by key audiences and may include unmarried adolescent girls, women not using contraception or who have experienced method failure, and women who live in high-risk or crisis settings.

Unmarried adolescent girls (15–19 years), in an urban or rural setting:

- Use ECPs when your method has failed or you had unprotected sex, including sex against your will.
- ECPs can be found in many pharmacies and health centers.
- ECPs are safe and effective, and you are allowed to use it (dependent on country context and legality of ECPs).
- Tell your peers about ECPs.
- Talk to providers at youth-friendly centers about ECPs.
- ECPs are an emergency method. Talk to your provider about starting an ongoing contraceptive method or using condoms to avoid future emergencies and pregnancies.

Women, married or unmarried, not using a contraceptive method or having experienced method failure:

- Use ECPs if you do not want to get pregnant now, but have had sex without using a contraceptive method.
- Use ECPs if you do not want to get pregnant now, but have had sex and your usual contraceptive method did not work—e.g., forgot to take the pill, condom broke.
- ECPs can be found in many pharmacies and health centers.
- ECPs are an emergency method. Talk to your provider about starting an ongoing contraceptive method or using condoms to avoid future emergencies and pregnancies.
- Talk to your provider and/or pharmacist about both ongoing and back-up contraceptive options.

Woman at risk of sexual violence, including intimate partner violence, and those living in humanitarian crisis settings:

- ECPs give you a chance to avoid a pregnancy when you had sex unwillingly, including with your husband or partner.
- ECPs can be found in many pharmacies, health centers and rape crisis centers.
- Talk to a counselor or GBV advisor about ECPs, post-exposure prophylaxis (PEP) for HIV and other post-GBV services.

Primary Audience 2: Pharmacy Staff

Objectives

By the year 2015, increase the percentage of pharmacy staff who:

1. Demonstrate accurate knowledge of ECPs' legal status in their country, mode of action, timing, dosage, side effects, effectiveness and proper utilization.
2. Serve all clients independent of age, marital status or previous use.
3. Are willing to discreetly counsel their clients on how to use ECPs and what to expect.
4. Provide clients coming for ECPs with information on regular modern family planning methods and refer clients to a nearby clinic in case they need additional counseling on ECPs or family planning in general.

Positioning

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

- Pride in position and providing long-term solutions to customers.
- Pride in having more skills.
- Prestige in being seen as knowledgeable and helpful.
- Satisfaction in helping women and families in improving their health.
- Pride in having satisfied clients return and refer friends and/or family.

Depending on country context, this positioning may need to be adapted. If the overall community does not support ECPs, then interventions need to be implemented to address this issue in the first place before using "prestige" as a motivational angle. Enhancing the provider's personal satisfaction in providing the right service for the community may be more relevant in that case.

Key Promise

If you choose to provide clients with ECPs as part of a comprehensive family planning service, including quality counseling, you will demonstrate your commitment to better health outcomes for your community and more people will come to you for advice and purchase of family planning products, as well as other drugs.

Support Statement

Clients value knowledgeable, trustworthy pharmacy staff who take time to counsel them effectively and demonstrate genuine interest in their health.

Key Messages

Key messages for pharmaceutical providers should seek to develop unbiased, knowledgeable and informative providers who understand the need to help women access an affordable option to avoid unwanted pregnancy.

Illustrative examples include:

- As a public health stakeholder and first point of information on contraceptives for many clients, you need to have accurate and up-to-date knowledge about ECPs, including side effects, efficacy and mode of action.
- ECPs do not cause abortion and cannot disrupt an existing pregnancy. They can only prevent a pregnancy from happening.
- ECPs can be taken up to five days after unprotected sex.
- ECPs are not only for sexual assaults or condom breakage cases—they can also be used when a contraceptive method was not used or when a contraceptive method failed.

Key Messages (continued)

- Provide advance ECPs for women at risk for sexual violence—it will not decrease contraceptive use or increase unsafe sex, it will only enable women to have faster access when needed.
- Repeat ECPs use has no long-term impact on health or fertility. Reassure your clients that ECPs are safe, even if used more than once.
- There is no evidence of a connection between teen and young adult use of ECPs and higher rates of STIs or HIV.
- Your clients count on you to counsel them on product efficacy and proper use, and by doing so you will increase their satisfaction and loyalty to your outlet for other purchases.
- You can improve health outcomes by taking time to share verbal or written information with potential ECPs clients.
- Adolescents can use ECPs. ECPs are safe for them, even if taken several times. (Targeting adolescents with ECP messages will depend on the legal/policy and social context of the country).
- Denying access to ECPs on the basis of age, marital status or repeat use is not ethical.

Primary Audience 3: Clinical Providers

Objectives

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

1. Demonstrate accurate knowledge of ECPs, including legal status in country, mode of action, mode of administration, effectiveness and side effects.
2. Can effectively help clients deal with the consequences of unprotected sex by counseling on the benefits and limitations of ECPs and providing ECPs.
3. Counsel ECP clients on the benefits of adopting a regular contraceptive method.
4. Are comfortable talking to adolescents and young women about ECPs.
5. Raise ECPs proactively in discussions about family planning methods generally to explain its use as a back-up method.

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 customers.
- Pride in having more skills.
- Prestige in being seen as knowledgeable and helpful.
- Satisfaction in helping women and families improve their health.
- Pride in having satisfied clients return and refer friends/family.

Depending on country context, this positioning may need to be adapted. If the overall community does not support ECPs, then interventions need to be implemented to address this issue first before using "prestige" as a motivational angle. Enhancing the provider's personal satisfaction in providing the right service for the community may be more relevant in that case.

Key Promise

If you make sure that your clients know about ECPs—as one of the contraceptive methods available to them—you will gain a reputation of being knowledgeable and helpful, and more clients will come to you for advice. They will see you as a trustworthy and quality provider. This will increase your prestige in the community and possibly your revenues.

Support Statement

People who have been helped and are happy with the outcome of their interaction with you will recommend your services to others. You will gain in status and recognition through word-of-mouth.

Key Messages

Key messages for providers should seek to develop confident, knowledgeable providers that embrace the concept that they can help women avoid unwanted pregnancies, improve their professional reputation and possibly increase their revenues (private sector)/decrease their workload (public sector).

Illustrative examples include:

- Ensure that you have accurate and up-to-date knowledge of ECPs, including legal status, benefits and side effects.
- ECPs do not cause abortions.
- ECPs cannot disrupt an existing pregnancy, they can only prevent a pregnancy from happening.
- ECPs can be taken up to five days after unprotected sex.
- ECPs are not only for sexual assaults or condom breakage cases—they can also be taken when a method was forgotten.

Key Messages (continued)

- Provide advice, support and high-quality service for a range of contraceptive methods to increase your reputation and better serve your community.
- Encourage all clients to use a reliable contraceptive method to prevent unintended pregnancies, including sexually active adolescents.
- Provide access to ECPs at your facility to ensure timely use.
- Inform clients seeking ongoing contraceptive methods about ECPs as a back-up method in case of emergency or method failure.
- Provide advance ECPs for women at risk of sexual violence—it will not decrease contraceptive use or increase unsafe sex, it will only enable women to have faster access to ECPs when needed.
- Provide access to ECPs to all clients irrespective of age, marital status and previous use.
- Help clients understand how to use ECPs for maximum effectiveness.
- Help clients understand that ECPs are effective, but also that the best protection against unintended pregnancy is an ongoing modern family planning method.
- Adolescents can use ECPs. ECPs are safe for them, even in cases of repeat use. (Targeting adolescents with ECP messages will depend on the legal/policy and social context of the country).
- There is no evidence of a connection between teen and young adult use of ECPs and higher rates of STIs or HIV.

Primary Audience 4: Community Health Workers or Distributors (public and private)

Objectives

By the year 2015, increase the percentage of community-based providers who:

- Demonstrate accurate knowledge of ECPs, including efficacy, mode of action, side effects and mode of administration.
- Can effectively help community members deal with the consequences of unprotected sex by giving them accurate information about ECPs (and possibly access to ECPs).
- Refer clients for access to and additional information about ECPs, if unable to provide ECPs themselves.
- Present unbiased information on ECPs to all community members, including adolescents and unmarried women, as part of a comprehensive family planning program.
- Refer clients to the relevant providers for other family planning methods.

Positioning

The key positioning for CHWs or distributors will be that providing information and services for ECPs will increase their pride, prestige among the community and satisfaction in the service they provide. These would be operationalized as:

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

Depending on country context, this positioning may need to be adapted—for example, if the overall community does not support ECPs, then interventions need to be implemented to address this issue first before using "prestige" as a motivational angle. Enhancing the CHW's personal satisfaction in providing the right service for the community may be more relevant in that case.

Key Promise

If you can provide accurate information about, referral for and access to ECPs as part of a comprehensive family planning program to your community members, you will be seen as knowledgeable, trustworthy and helpful in your community (and also increase revenues, if appropriate to country context where community distributors sell the product).

Support Statement

Community members will feel comfortable talking to you about their problems related to unintended pregnancies or unprotected sex and will look for information and guidance about what to do. They will refer their peers and friends if they are satisfied.

Key Messages

Key messages for community-based providers should seek to develop open, trustworthy, reliable providers who care deeply about their community and want to help women choose when to become pregnant. They do not judge the behaviors of their community members and provide unbiased information.

Key messages for this group may include:

- Your community relies on you as a trusted provider to give them information about what to do when they are at risk of unintended pregnancies.
- Your community members may be impressed to know that you have the most up to date information (efficacy, mode of action and possible side effects) on contraceptive options, including ECPs.
- As the first point of contact at the community level for information on ECPs and other contraceptive methods, you have a key role to play in ensuring the well being of your community members.

Key Messages (continued)

Basic information about ECPs should also be communicated through simple key messages.

- ECPs consist of two pills taken after unprotected sex to avoid pregnancy.
- ECPs are most effective when taken immediately after unprotected sex, but they can be effective up to five days after unprotected sex.
- ECPs are safe and have very limited side effects that are temporary and will disappear after use.
- Repeat use of ECPs has no long-term impact on health or fertility.
- ECPs cannot disrupt an existing pregnancy; they can only prevent a pregnancy from happening.
- ECPs are a back-up option and should not be used instead of a regular contraceptive method.
- ECPs do not protect against HIV and other STIs. Couples should always use a condom to prevent HIV and other STIs.
- ECPs are safe for adolescents, even if taken more than once, adolescents can use ECPs. (Targeting adolescents with ECP messages will depend on the legal/policy and social context of the country).

Primary Audience 5: Responders to Gender-Based Violence, Including Those in Crisis Settings

Objectives

By 2015, increase the percentage of people dealing with reproductive health issues in crisis settings and people who are first in line for sexual assaults (e.g., police officers) who can:

1. Demonstrate accurate knowledge of ECPs, including efficacy, and modes of action and administration.
2. Present unbiased information on ECPs to all women forced into sex, including adolescents, and unmarried and married women.
3. Effectively give access to ECPs either directly or through referral.
4. Refer women to nearby health centers for other services, such as post-exposure prophylaxis for HIV and other GBV services.

Positioning

First line response—in the context of a crisis, such as rape or coerced sex, you are first in line to help women avoid unwanted pregnancies and HIV. As such, you are well positioned to take essential steps to help them rapidly and effectively as they deal with the aftermath of sexual assault.

OR

Give peace of mind to survivors of sexual assault. When someone is raped or coerced into having sexual relationships, you can help them avoid unwanted pregnancies and HIV and contribute to their peace of mind while they deal with the aftermath of a sexual assault.

Key Promise

By offering accurate, timely information and access to ECPs, you will gain in reputation and prestige, as well as get a sense of personal reward by being able to contribute to better health outcomes for survivors of sexual assaults.

Support Statement

In your position as "first-line responder" to survivors of sexual assaults, you have the knowledge and authority to bring appropriate help to women at a time when they are highly vulnerable.

Key Messages

Key messages targeting GBV workers should highlight ways that they can help survivors of sexual assaults. Some messages should also highlight the need to establish a comprehensive program to assist affected populations.

Illustrative examples include:

- You can provide compassionate and confidential treatment to survivors of sexual violence.
- You can provide information about ECPs in an accurate and timely fashion, at the time when the sexual assault is being reported.
- You can share information about ECPs, such as when to take it, how to take it, how effective it is and possible side effects.
- You can provide access to ECPs—either directly or by referring the woman to a nearby source where you know she will get it easily (and preferably for free).
- You can liaise with other stakeholders to ensure a comprehensive plan is in place to provide support to affected populations.

Countries and regions need to establish a comprehensive response mechanism for GBV and involve all relevant stakeholders (e.g., Ministry of Health (MoH); local and international development, humanitarian and civil society NGOs/organizations with relevant expertise and experience; representatives from the affected communities; and UN agencies, such as UNFPA, UNHCR, UNICEF and WHO).

Influencing Audience: Supportive Male Partners and Friends

Objectives

By 2015, increase the percentage of supportive partners and peers who:

1. Talk to their peers or partners about the risk of unwanted pregnancies.
2. Demonstrate accurate knowledge of ECPs, including efficacy, and modes of action and administration.
3. Can give peers/partners accurate information about ECPs.
4. Know where to refer partners/peers for product access (local pharmacy, local clinic).
5. Encourage partners/peers to access ECPs if needed.

Positioning

Men: Do not let life catch you by surprise. You can control your life even when things do not go as planned.

Friends/peers: For young women interested in seeing their friends and peers succeed, knowing and sharing information about ECPs will make them seem knowledgeable and stand out as a leader whom their peers can turn to with questions or problems.

Key Promise

Men: ECPs can help you and your partner avoid an unintended pregnancy when your method has failed or you had unprotected sex.

Friends/peers: By showing support to your peers, you will gain in reputation and social status. You will feel personally rewarded knowing you have helped your friends avoid a negative situation that is not beneficial to their health or to their education.

Support Statement

Men: Men and women can make the decision together to use ECPs to avoid an unintended pregnancy.

Friends/peers: By helping others, you can create the social support that you and others need; you can also increase your sense of being helpful to your community.

Key Messages

General messages for male partners and peers include:

- ECPs consist of two pills taken after unprotected sex to avoid unintended pregnancy.
- ECPs are most effective when taken immediately after unprotected sex, but they can be effective up to five days after unprotected sex.
- ECPs can be found in many pharmacies and health centers.
- ECPs do not terminate an existing pregnancy, they only prevent pregnancies.
- ECPs are safe and have very limited side effects that are temporary and disappear after use.
- ECPs are a back-up option and should not be used instead of a regular contraceptive method.
- ECPs do not protect against STIs and HIV. Couples should always use a condom to prevent STIs and HIV.

For supportive partners:

- Unwanted pregnancies can create a lot of emotional and financial stress.
- ECPs provide couples a chance to avoid an unwanted pregnancy when they had unprotected sex or their contraceptive method failed.
- ECPs are safe and effective and every woman of reproductive age is allowed to use them, independent of her age or marital status.
- Talk to your partner about ECPs and contraception.
- Go with your partner to talk to a provider about ECPs and other contraceptive methods.

Key Messages (continued)

For peer/friend:

- Unwanted pregnancies can create a lot of emotional and financial stress, or force young girls to drop out of school.
- When a woman has unprotected sex or experiences method failure, ECPs provide a chance to avoid an unintended pregnancy.
- Talk to your friends about ECPs and the use of ECPs if condoms or another contraceptive method was not used.
- Encourage your friends who may be at risk of unintended pregnancies to talk to a trained peer or provider about ECPs.
- Accompany your friend to access ECPs and provide your support.

Step 5: Determine Activities and Interventions

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

Suggested approaches and activities are presented here as appropriate choices for communicating to primary and influencing audiences about ECPs. 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.

In crisis settings, ECPs should be provided as part of a comprehensive programmatic intervention. For more information, consult the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations—Distance Learning Module by the Women's Refugee Commission (http://misp.rhrc.org/).

Mass Media

Intervention Area	Illustrative Activities	Purpose	Intended Audience
Short-form mass media	TV or radio ad addressing major misconceptions on ECPs and benefits of using ECPs.	To raise awareness.	Women of reproductive age (WRA) Male partners Peer/friend
Long-form mass media	Radio or TV drama	To increase awareness and correct knowledge. To change social norms.	WRA Male partners Peer/friend
Print media	• Photo novella. • Magazine or newspaper ad/story read by the intended audience.	To increase awareness and correct knowledge.	WRA Male partners Peer/friend
Digital media and mHealth	• Hotline number for one-on-one counseling. • Free texting for standard information. (The MAMA partnership has developed adaptable messages that include emergency contraception and 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.) • Informational websites. • Facebook page.	To increase awareness and knowledge of correct timing and dosage/mode of action and when to use.	WRA Male partners

Outlet-Based Interventions (pharmacies, drugstores)

Intervention Area	Illustrative Activities	Purpose	Intended Audience
Pre-service training	Integrate ECPs into pre-service training curricula.	To increase awareness.	Pharmacy staff
Medical detailing	• Visits to pharmacies by trained detailers on a regular basis to create relationship with outlet staff and change behaviors. • Communication of key messages and information to help outlet staff counsel clients properly.	To increase accurate knowledge of ECPs. To correct misconceptions. To help answer questions.	Pharmacy staff
Job aids	"Cheat sheet" with dosage card that pharmacy staff can use to communicate key messages about ECPs to clients.	To ensure correct knowledge and key messages are covered for each client.	Pharmacy staff
Digital/distance learning	• Hotline or SMS service. (The MAMA partnership has developed adaptable messages that include emergency contraception and 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.) • Sharing latest research and practice. • Publication/distribution of professional journals.	To increase accurate knowledge. To increase confidence for administration of ECPs. To address biases.	Pharmacy staff
Point-of-sale materials	Brochure for clients to take home and read.	To increase knowledge among clients.	WRA Male partners Peers/friends
In-service training	• Integrate ECPs into existing curricula. • Develop or revise clinical guidelines for ECPs. • Organize meetings with national or regional medical and/or pharmaceutical associations.	To increase accurate knowledge.	Pharmacy staff
Social marketing of a low-priced product	Work with an SM organization to introduce a subsidized and/or low-priced product and ensure distribution throughout the country.	To increase availability and affordability.	WRA Male partners
Incentive scheme	Reward pharmacies and outlets that carry the product with special offers or promotional materials.	To increase availability.	Pharmacy staff

Clinic-Based Services

Intervention Area	Illustrative Activities	Purpose	Intended Audience
Pre-service training	Integrate ECPs into pre-service training curricula for all providers, including doctors, nurses, midwives.	To increase awareness.	All medical staff (physicians, nurses, midwives)
In-service training	• Integrate ECPs into existing medical curricula. • Develop or revise clinical guidelines for ECPs.	To increase accurate knowledge. To increase confidence for administration of ECPs.	All medical staff (physicians, nurses, midwives)
Clinic services	• Introduce ECPs counseling and administration as part of comprehensive family planning services in clinics—through public, private or NGO sectors. • Train or update providers on ECPs administration and dosage. • Develop counseling job aides.	To increase access. To facilitate link with other contraceptive methods. To address provider bias.	All medical staff (physicians, nurses, midwives)
Medical visits to clinics	Offer in-person support through supportive supervision visits and on-the-job training.	To address provider bias and knowledge. To increase accurate knowledge.	All medical staff (physicians, nurses, midwives)
Incentive scheme	Reward clinics that offer the product with special offers or promotional materials.	To increase availability.	All medical staff (physicians, nurses, midwives)
Digital/distance learning	• Offer distance support for medical staff through a hotline or texting options with trained medical personnel. • Access to web-based information via cell phones. • Sharing latest research and practice. • Publication/distribution of professional journals. • Organize clinical meetings with national or regional medical associations.	To increase accurate knowledge. To increase confidence. To increase acceptability. To increase coverage.	All medical staff (physicians, nurses, midwives)
Point-of-sale materials	Brochure for clients to take home and read.	To increase accurate knowledge.	WRA Male partners
Job aides	"Cheat sheet" with dosage card to communicate key messages about ECPs to clients.	To ensure correct knowledge and key messages are covered for each client.	All medical staff (physicians, nurses, midwives)

Community-Based Services, Outreach and Community Approaches

Intervention Area	Illustrative Activities	Purpose	Intended Audience
CHW outreach	• Integrate key messages on ECPs into existing curriculum for CHWs. • Develop/adapt materials and job aides to provide guidance on counseling and referral for ECPs. • Provide CHWs with sample products. • Allow CHW to distribute and administer ECPs. • Develop formal referral system between CHW and clinics using non-monetary incentives such as allowing referred clients to be seen quickly positively impacts on the prestige of the CHW in the community. • 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 badges, buttons and other items that support the central positioning and promotion of quality.	To increase awareness and accurate knowledge. To increase access. To address misconceptions.	Community-based providers
Peer-to-peer interventions[5]	• Train young women who had an unintended pregnancy or know someone close who had an unintended pregnancy to counsel their peers about ECPs. • Leverage campus media and youth-friendly marketed (soft-sell) magazines.	To increase awareness and acceptability. To change social norms.	Young women
Community approaches	• Hold community theatre and dialogues around reproductive health and maternal and child health, including ECPs and family planning, using satisfied users (and their partners) as key advocates. • Organize discussion groups for men, women and/or couples and/or young people.	To increase social support for ECPs.	WRA Male partners Peers/friends

Police Stations and Crisis Settings

Intervention Area	Illustrative Activities	Purpose	Intended Audience
Training and distribution	• Train police officers on comprehensive care for sexual assault survivors and how they can provide women with the help and assistance they need. • Allow police officers to administer ECPs.	To increase awareness. To strengthen referral system to gender-based violence services.	Police officers
Referrals	Brief police officers to refer rape survivors to local hospitals or clinics for treatment.	To increase awareness. To improve access. To strengthen referral system to gender-based violence services.	Police officers
Printed informational material	Develop flyers to inform women about why and where to access care for rape.	To increase awareness.	Women survivors of sexual assaults Peers/friends
Referrals	• Brief soldiers and/or aid workers to refer rape survivors to local clinics for treatment. • Use midwives/TBAs as "focal points" or to deliver messages and encourage women to come confidentially and get referred as needed.	To increase awareness. To improve access. To strengthen referral system to gender-based violence services.	Staff working in a crisis setting Women survivors of sexual assaults
Women's centers	Establish safe care areas where women can come for advice and help confidentially.	To improve access.	Staff working in a crisis setting Women survivors of sexual assaults

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

Refer to page 25 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 illustrative indicators are examples of useful indicators for measuring program inputs, outputs, outcomes and impact.

Women of reproductive age:

- Number of television spots aired on TV. (Monitoring – communication channel statistics)
- Proportion of women of reproductive age who believe ECPs are a healthy and acceptable option. (Evaluation – omnibus survey or nationally representative survey)
- Number of instances of ECPs use following demand generation campaign. (Evaluation – service statistics)
- Proportion of family planning users using ECPs in the past 12 months. (Evaluation – DHS or nationally representative survey)
- Proportion of WRA who report that they talked to their spouse about family planning options, including ECPs. (Evaluation – omnibus survey or nationally representative survey)
- Proportion of WRA who report that they know where to access information and services for ECPs. (Evaluation – omnibus survey or nationally representative survey)
- Proportion of women who have heard of ECPs. (Evaluation – omnibus survey or nationally representative survey)
- Proportion of women who know where to find ECPs. (Evaluation – omnibus survey or nationally representative survey)
- Proportion of women who have correct knowledge about ECPs. (Evaluation – omnibus survey or nationally representative survey)
- Proportion of women who think that ECPs are affordable. (Evaluation – omnibus survey or nationally representative survey)
- Number of households visited by non-clinical providers. (Monitoring – provider self-reported data)

Providers:

- Number of clinical providers trained on ECPs. (Monitoring – program records)
- Number of referrals made by non-clinical providers using counseling cards. (Monitoring – provider self reported data)
- Proportion of clinical providers who report that they have high self-efficacy for provision of ECPs. (Evaluation – provider self reported data or survey)
- Proportion of providers with accurate knowledge of ECPs, including mechanism of action, effectiveness, mode of administration and side effects.
- Proportion of providers who feel confident and comfortable counseling clients and administering ECPs.
- Number of ECPs clients counseled and served on a monthly basis. (service statistics)

Pharmacists:

- Proportion of outlets carrying ECPs. (Monitoring – survey data or mystery shopper visits)
- Number of pharmacists trained on ECPs. (Monitoring – program records)
- Proportion of pharmacists with accurate knowledge of ECPs, including mechanism of action, effectiveness, mode of administration and side effects. (Evaluation – provider self reported data or survey or mystery shopper visits)

- Proportion of pharmacists who feel confident and comfortable counseling clients and administering ECPs. (Evaluation – provider self reported data or survey)
- Number of ECPs clients served on a monthly basis. (Monitoring – service/sales records)

Community-based workers:

- Proportion of CHWs with accurate knowledge of ECPs, including mechanism of action, effectiveness, mode of administration and side effects. (Evaluation – provider self reported data or survey)
- Number of CHWs trained. (Monitoring – program records)
- Proportion of CHWs who feel confident and comfortable counseling clients (and administering ECPs). (Evaluation – self reported data or survey)
- Number of ECPs clients referred on a monthly basis. (Monitoring – service/sales records)

Crisis settings:

- Number and type of sites offering ECPs as part of services.
- Number of those who experienced sexual violence counseled on ECPs (and provided with ECPs or received referral). (Monitoring – service/sales records)

Male partners/peers:

- Proportion of male partners and/or peers who reported viewing TV spots related to ECPs. (Monitoring – nationally representative surveys)
- Proportion of male partners and/or peers who report that ECPs are a healthy and acceptable option. (Evaluation – omnibus surveys or nationally representative surveys)
- Proportion of male partners and/or peers who report that they talked to their spouse and/or friend about ECPs. (Evaluation – omnibus surveys or nationally representative surveys)

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