




CASE STUDIES

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(<http://sbccimplementationkits.org/service-communication/case-studies/case-study-service-communication-strategy-in-action/>)

Appendix I – Zimbabwe: Challenges in Getting Clients to Services

Before services can be delivered, a client needs to access them. How does that happen? It seems straightforward enough: the Ministry of Health uses posters and perhaps radio spots to announce the service and where to get it. Then, clients who need the service will simply come. But it is rarely that easy. Just communicating information is often not enough to get clients to services.

Challenge

If people acted rationally based on what is proven to be best for them, everyone would avoid sugary snacks, immunize their children, get enough exercise and never start smoking. The truth is that people are not wholly rational actors; we make decisions based on our beliefs and emotions, even when those beliefs and emotions contradict overwhelming evidence. The challenge is to communicate effectively about a service in a way that motivates the desired behavior. People need not only to know about the service, but also to understand its value to them, feel like they can access it, know where to get it and feel able to navigate the barriers to access.

Barriers to access extend beyond individual knowledge, ability or attitudes. Relationships and communities can also influence individual willingness and capacity to go to health services. This could be through actively obstructing an individual or the general perception that the

Barriers to Young People Accessing Sexual and Reproductive Health Services

Individual barriers – Lack of understanding of reproduction and sex. Desire to “become a woman or man” by having a child. Belief that healthcare is for women only. Poor experience/stigmatizing behavior by providers who believe young people should not access sexual and reproductive health services.

Community norms – Parents feel inhibited from talking about sexuality with their children. Belief among adults that talking about sex encourages promiscuity. Cultural norms that encourage early marriage for girls or cross-generational relationships.

Policy barriers – Condom distribution sales are restricted by age. National sexual and reproductive health curriculum is not comprehensive (abstinence based). Government does not prioritize youth as a key population for family planning. Policies require a woman to be married to access family planning.

services are inappropriate or wrong. Lastly, external conditions such as physical or logistical barriers and gender and cultural norms can prevent service uptake.

Response

By using social and behavior change communication (SBCC) techniques rooted in behavioral science, service communication can inform and motivate individuals to access services and create an environment that promotes health-seeking behaviors.

Commercial marketing has long appreciated the power of emotion to sell products and services. SBCC has adapted commercial marketing techniques to go beyond demographics or behavioral data, seeking to understand **why** clients invest their time and money and associating services and health behaviors with client values and aspirations. Effective communication uses these insights in developing messages, selecting approaches and channels, and sequencing their delivery.

In using the **socio-ecological model** (page 16), SBCC recognizes the influence that a client's environment has on decision-making. Family, friends and community all play a part in encouraging (or deterring) a client. At a higher level, policies can influence the availability of services, and advocacy – a component of SBCC – can be used to make services available.

The Demand Generation SBCC Implementation Kit

(<http://sbccimplementationkits.org/demandrmnch/>) provides a step-by-step process to build demand for key services and products.

Audience Insight - VMMC in Zimbabwe

Challenge

Voluntary medical male circumcision (VMMC) is a priority for HIV prevention in Zimbabwe. The national policy aimed to reach 80 percent of 13- to 29-year-old Zimbabwean males (about 1.3 million young men) between 2011 and 2015. PSI provided technical and financial support to the Ministry of Health and Child Welfare to reach that goal. The program has 20 fixed sites, multiple outreach sites and mobile teams across all 10 provinces and offers VMMC through routine and

campaign service delivery models. Launched in 2011, the *Pinda muSmart* (Get Smart) campaign positioned VMMC as a lifestyle choice of the *smart, clean man*. It used celebrity endorsements, appealing to trendsetters to be “ahead of the pack.” Despite this effort, results lagged. A World Health Organization progress brief calculated that by the end of 2014, Zimbabwe had circumcised more than 412,000—only 22 percent of the country’s target of 1.3 million men. This situation was not unique to Zimbabwe; many countries were falling short of their VMMC targets.

PSI has long used commercial marketing techniques – most of their products and services are branded for maximum appeal to the intended audience – and they conduct multi-level promotional campaigns using mass media and social mobilization to share their messages. But these techniques were proving inadequate.

Response

In a demand-creation meeting in 2013, the Gates Foundation engaged the market research firm Ipsos to work with the Ministries of Health in Zambia and Zimbabwe to gain insights as to why these well-executed campaigns were not achieving the expected results. The research sought to:

- Understand the decision-making process for men intending to undergo VMMC (including the impact of influencers)
- Identify physical and emotional drivers and barriers for VMMC uptake and the impact of the social environment
- Identify existing awareness, knowledge, perceptions and gaps related to VMMC
- Design a tailored communication and service approach for men seeking VMMC services
- Identify and map key stakeholders’ information gaps and use this research in the strategy

Qualitative country-level research enabled Ipsos to segment Zimbabwean men based on their level of awareness, belief and commitment to action. In particular, they identified **cognitive dissonance** in many men who understood the benefits of VMMC and health-seeking behavior, but had not been circumcised

(<http://www.simplypsychology.org/cognitive-dissonance.html>). The research identified key factors that influence real action and, based on these factors, Ipsos quantified the potential opportunity for each group based on current circumcision rates among:

1. VMMC enthusiasts
2. VMMC **neophytes**
3. Scared rejecters
4. Embarrassed rejecters
5. Highly resistant

In 2015, PSI convened a workshop to review the research and map out how best to utilize it. Based on the potential opportunities presented by each segment, Zimbabwe decided to prioritize VMMC enthusiasts, VMMC neophytes and embarrassed rejecters.

The PSI team identified common motivators between neophytes and embarrassed rejecters, who were collectively estimated to represent 56 percent of uncircumcised men. Because the research went beyond gathering the typical demographic data (e.g., age, education, geographic location) and explored men's unique values, motivations and feelings often not captured in formative research, the resulting messages for mass media, IPC and advocacy, were based on the **functional** and **emotional** benefits identified for each group (<http://sbccimplementationkits.org/service-communication/case-study-1-challenges-in-getting-clients-to-services/>).

In other words, the research asked potential clients what they believed the utility – functional benefits – of VMMC would be (e.g., reduced risk of HIV infection), as well as what positive feelings they associated with VMMC (e.g., feeling sexually attractive or feeling like a responsible sexual partner).

In the past, PSI used its highly trained researchers to collect additional information in the field and bring it back to the SBCC experts, who would design messages through a marketing strategy design workshop called “Delta.” The draft messages would then be pre-tested and rolled out at a national level. Using a new approach, PSI employed techniques adapted from human-centered design to develop

strategies and messages. The PSI team shadowed their intended audiences, spending time with them to observe an average day's routine.

Results



My name is Zivai and I am 24 years old. I live in Murambinda, Zimbabwe. I work as a dealer in cellphones, airtime, laptops, etc. I have 3 family members including my mum, sister and brother. I am single but I can have multiple partners at one time. For fun I like to drink and *braai* with my friends.

“The other boys, my friends, are advocating for male circumcision in the area. We even have a song to encourage each other. I never thought of withdrawing from doing the procedure.”

Zivai's values:

- He's strongly motivated by the "sex drive" benefits of getting circumcised
- He's very concerned about how his life will change after the procedure
- Sees himself as a "leader of the pack" and has strong social support behind him

Market research, combined with the human-centered design process, has enabled the PSI marketing and communication team to develop archetypes based on attitude and behavior toward VMMC. The image above offers an example of an “enthusiast” archetype.

Field staff are adapting a tool [see version] created during the research (a series of questions set up like a decision tree) to quickly segment clients into archetypes. This typing tool allows mobilizers to tailor their messages most persuasively. The tool, which is based on psychographics rather than typical demographic data, uses color-coded guidance to help mobilizers categorize each potential client into one of the key segments and then tailor messages that speak to the specific motivators and barriers of each segment. This helps ensure that one-on-one and small-group interactions are more efficient and effective in addressing the real needs of men.

The tool uses colors instead of segment labels (e.g., blue instead of “VMMC neophyte”) as an internal guide for mobilizers. This system has been piloted since February 2016 with plans for national rollout in July. Community mobilizers report

that the approach has made their efforts more efficient. They no longer have to give a whole speech, but can confidently start with a few highly effective messages based on the potential client's segment.

Ipsos' research noted common themes among the determinants of VMMC-seeking behavior among men. One was the importance of former clients' becoming VMMC champions and advocating for the service among their peers. Unfortunately, very few men were converting to VMMC champions after receiving the procedure. Another common barrier noted in the research was that messages minimized discussion of the pain men would experience, both during the procedure and throughout the healing process. Further probing found that some clients were surprised when they did feel pain and felt deceived. This left them less likely to advocate with their friends to go for circumcision. Because word of mouth was identified as a powerful way to get men into VMMC services, it was important to address the issue of pain directly. Using human-centered design approaches, the PSI team brainstormed around this challenge, creating prototypes and testing them with clients. Using feedback and input from real men, the *Pain-o-Meter* job aid was born. The Pain-o-Meter allows mobilizers to talk honestly about pain so potential clients have clearer expectations about pain during the procedure and in the healing period.

The Ipsos findings also indicated that if men became champions, they preferred to use their own words to describe their experiences. They

What is Human-Centered Design?

Human-centered design is a creative approach to problem-solving ... that starts with the people you're designing for and ends with new solutions that are tailor made to suit their needs. Human-centered design is all about building a deep empathy with the people you're designing for, generating tons of ideas, building a bunch of prototypes, sharing what you've made with the people you're designing for, getting their feedback and consistently refining and reiterating, and eventually putting your innovative new solution out in the world.

Human-centered design consists of three phases. In the Inspiration Phase you'll learn directly from the people you're designing for as you immerse yourself in their lives and come to deeply understand their needs. In the Ideation Phase you'll make sense of what you learned, identify opportunities for design and prototype possible solutions. And in the Implementation Phase you'll bring your solution to life, and eventually, to market. Throughout the work, you've kept the very people you're looking to serve at the heart of the process. **More:** <http://www.designkit.org/human-centered-design>




asked the researchers to provide triggers rather than messages. Clients suggested that a mug or cap could be a conversation starter that allows the champion to tell his story, describe why circumcision was important to him, and talk about its benefits.

Engagement of field-level workers and the clients provided PSI with invaluable feedback to optimize the effectiveness of their tools and messages. PSI has begun to embrace the concept, popular in design work, of “failing fast,” which refers to using prototypes and iterative development to allow for rapid adaptation based on feedback and experience. Prototypes, which are simple, rough, facsimiles of the tools, materials or experiences, are taken out and used (rather than pre-tested with a focus group). Prototypes differ from pre-tests in that the materials are far less fully formed and the ideas can go through major changes and transformations, even being thrown away entirely, without large sunk costs for design and human resources. The prototyping process also allows messages to go through constant adaptation as the experiences and needs of the mobilizers and clients are better understood.

Application

Understanding the intended audience is critical to effective communication, not just to understand their barriers and motivators, but also to empathize with their situations and engage them in finding solutions. Large-scale research can provide good documentation, and solid data can provide trends and rates, but careful observation, curiosity, and empathy can generate even deeper insights that allow for co-creation of effective messages and tools.

Prioritized Audience Segments and Their Potential for Seeking VMMC

-  **VMMC Enthusiasts**
Large potential (21% of uncircumcised men) and high commitment already; need to overcome some dissonance issues
-  **VMMC Neophytes**
Large potential (19%) but lack of knowledge is key to informing their commitment; addressing knowledge gap is relatively easy
-  **Embarrassed Rejecters**
Moderate potential (16%) but commitment is rather low and knowledge, embarrassment and fears are high; need a lot of support

ADDITIONAL RESOURCES

Demand Generation I-Kit for Underutilized, Life Saving Commodities

Field Guide to Human-Centered Design

Male Circumcision Demand Generation Meeting Report. January 2015. Bill & Melinda Gates Foundation.

Bukuku, M. Presentation from SBCC Summit. February 2016. How to Link Demand Creation and Health Services: Experiences from Tanzania.

EngenderHealth and Promundo. 2008. Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers. The ACQUIRE Project. Washington DC: USAID.

Research Triangle Institute and Population Services International. 2014. Voluntary Medical Male Circumcision (VMMC) Demand Creation Toolkit. Washington DC: US Centers for Disease Control and Prevention.

Sutton, SM, Baich GI, and Lefebvre RC. nd. Strategic Questions for Consumer-Based Health Communications.

Appendix J – Kenya: Client/Provider Challenges

The *during* stage of service communication comprises the interactions and communication (verbal and nonverbal) that take place while services are being offered. These interactions involve the client and service provider, as well as receptionists, schedulers, security personnel, and even those who clean the facility. Client/provider interactions may take place in a facility setting, but could include outreach and mobile services. Effective interactions usually reflect a client-centered approach to service delivery, which views a patient holistically rather than as a body part, disease, or condition; promotes courteous treatment of clients; and ensures clear and accurate communication tailored to the client's needs.

Challenge

In the real world, there are many constraints to effective client/provider interactions. The facility environment can be challenging; a busy practice, lots of patients, and heavy workloads push staff to deal with clients as quickly as possible. Medical training can focus on pathologies and conditions rather than viewing a patient as a whole person, and clinical data collection promotes this notion by reporting on services rendered or test results rather than health outcomes. In addition, providers naturally make assumptions based on experience and personal attitudes resulting from cultural and traditional norms and personal beliefs. These biases can negatively influence care and result in stigma, discrimination, or even abuse of clients. Similarly, clients' expectations have an impact on client/provider interaction; it is hard to appropriately diagnose and treat clients if they are too deferential, do not understand what information is important and why, or are afraid to be honest. Client expectations may implicitly or explicitly push providers to give injections or prescribe antibiotics, even if such treatment is not indicated. Lastly, if clients don't understand why they received a service or what they need to do for follow-up, they may not get better or return to the health facility.

Response

Communication cannot address all of the problems tied to the physical environment or availability of products and services, but it can improve interactions between clients and providers. Counseling skills are critical—not just being able to

provide information, but also being able to listen and respond to client concerns in a way that makes the person feel heard and accepted and helps the client feel able to make healthy choices after they leave. Training to address sensitive topics, such as sexuality, gives providers technical skills and helps them overcome the social and cultural biases that impede effective service delivery. Effective counseling also helps clients articulate their expectations and gives the provider an opportunity to address and manage those expectations in a respectful way. Finally, coaching and supportive supervision with the provider can create a positive environment for service providers to adopt new behaviors and refine new skills. Well-designed materials reinforce messages for the client and act as job aids for providers. Such materials can also provide reminders and support to clients after they leave.

Case Study: Men's Sexual Health and Rights Program – Kenya

Challenge

Key populations – men who have sex with men (MSM), sex workers and people who inject drugs – are disproportionately affected by HIV and AIDS. Societal attitudes about their behaviors, including criminalization, have made it difficult to openly discuss their risks or address their needs. For example, HIV prevention messages rarely discuss same-sex practices and behaviors, so some MSM are not even aware that their behavior could put them at risk for HIV. Prevention and treatment services to address the specific health needs of MSM are beginning to roll out across Africa, but too often services are inappropriate; service providers don't know what questions to ask, lack skills to provide care, and may unwittingly or purposefully stigmatize and discriminate. Even providers who are willing to work with MSM, often have no training on how to ask about client history using appropriate language or how to identify, manage and treat STIs. When some providers are respectful, other facility staff members can be abusive, leaving clients unwilling to continue care or treatment. In turn, service providers face risks of marginalization within the facility or from the wider community or law enforcement.

Response

The Men's Sexual Health and Rights Project (SHARP) was designed to reduce the spread and impact of HIV among MSM and build healthy MSM communities in Kenya, Tanzania, Uganda, and Zimbabwe. Coordinated by the International HIV/AIDS Alliance with funding from the Danish Department for International Development, SHARP ran from December 2012 to November 2015. The project provided a basic package of sexual health services tailored to country contexts, including education and small group discussions, condoms and lubricants, HIV testing and counseling, sexual and reproductive health and rights counseling, and referral for HIV treatment.

SHARP's partners—Seven community-based organizations led by MSM for MSM—established partnerships with health facilities (mostly public sector) to ensure access to a comprehensive package of health services. The challenging country contexts required significant investments to sensitize, build, and strengthen relationships. SHARP developed intensive clinical training to cover social, biomedical, and community-based elements relevant to holistic MSM health, including management and treatment of HIV and other sexually transmitted infections (STI).

The Men Against AIDS Youth Group (MAAYGO) works in western Kenya to promote the health, acceptance, and well-being of MSM and other sexual minorities. Through SHARP, MAAYGO and the Kenya AIDS NGO Consortium (KANCO) hosted a training delivered by **Health4Men**, a South African NGO responding to HIV among gay, bisexual and other MSM, to ensure that service providers could offer competent and non-discriminatory healthcare and support to MSM (<http://www.health4men.co.za/>). Training topics included locally appropriate diagnosis and treatment of the STIs that are most common in the MSM community, a review of the comprehensive package of services for key populations established by the Kenya National HIV/AIDS Strategic Plan, and the impact of stigma and discrimination on MSM, particularly on individual health status. Training sessions emphasized the importance of principles of confidentiality, non-judgmental care, and cultural competence, and how those translate into healthcare services for MSM. For instance, trainers delved into appropriate language to use in clinical

notes. Recognizing that training one or two individuals in a clinic is not sufficient enough to change the clinical environment, training was conducted with key facility staff from Kisumu District Hospital and 12 other facilities in the region.




Involving all staff (including senior management and support personnel working on the clinic compound) ensured that MSM received respect from the moment they arrived for services.

Repeated training gave hospital staff multiple opportunities to assess and build their knowledge, understanding, and clinical practices.

As a first step, MAAYGO asked healthcare workers to explore their own biases. The values inventory gave facility staff an opportunity to reflect on their personal norms and judgments around issues of sex and sexuality, how these values could affect the quality of service delivery, and how these values might come into conflict with ethics of healthcare (such

as universal right to health or “do no harm”). The training environment gave providers a safe space for questions that would be inappropriate or intrusive to ask clients. In addition, to the trainings, MAAYGO worked with clinicians to expand access to services, creating moonlight services set up near “hotspot” areas where MSM typically gathered. MAAYGO used trained peer mobilizers to promote HIV testing and STI screening, with confidence that services would be respectful and appropriate. By sensitizing local law enforcement, MAAYGO was also able to better guarantee client safety, a serious concern for many potential clients. Other SHARP partners in East and Southern Africa have created feedback mechanisms to assure and improve service delivery. Using a “mystery shopper” approach, SANA in Tanzania and GALZ in Zimbabwe sent a volunteer unannounced to receive services, as any client would, to examine how friendly and competent the services were or to

Course outline of training offered by Health4Men

SECTIONS	MODULES	ELEMENTS
 MSM sensitisation	Opening and Key Populations	<ul style="list-style-type: none"> • Definition of terms • Key populations and 'at risk' populations globally and in East Africa • Differential risk • MSM and the general population
 MSM medical management	Sex, sexuality and sexual identity	<ul style="list-style-type: none"> • Relationship between sex, sexuality and sexual identity • Sexuality and sexual identity • Links and discontinuities between sexual identity and sexual behaviour • MSM sexual identities and sexual behaviours
 MSM community outreach and NGO/CBO development	Healthcare provider and MSM	<ul style="list-style-type: none"> • MSM right to healthcare • Impacts of stereotypes and prejudice • Necessity for MSM to be able to access healthcare
	A sex positive approach	<ul style="list-style-type: none"> • Health4Men's non-judgemental approach to MSM healthcare • Terminology • Recommended actions when engaging MSM in healthcare setting

follow up on reported problems with a trained service provider. Such feedback allows service communication programs to refine counseling training to reflect client feedback and enables supportive supervision to focus on specific areas for provider behavior change.

Results

Pre- and post-tests from the Health4Men training showed that participants increased their basic psychosocial knowledge and more advanced biomedical knowledge from 64–88 percent. Homophobic stigma decreased by one-third among participants (from more than 18 points to 12 points on a scale adapted from a [2012 study on MSM and healthcare services](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852129/): <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852129/>).

By being sure that MSM would receive respectful care, SHARP partners were able to increasingly support and refer clients for critical HIV services, including HIV testing and STI screening. By the end of the project, SHARP had reached almost 15,000 MSM in the four countries (exceeding the project target by 80 percent—a sevenfold increase from the baseline). This included more than 2,500 MSM in Kenya whom MAAYGO mobilized to receive their HIV test results and more than 2,000 MSM who were screened and tested for STIs.

Application

Although the healthcare situation for MSM may seem exceptional, healthcare workers often encounter individuals who are marginalized by society or feel vulnerable because of their health condition. Client-centered service communication delivers messages that acknowledge these vulnerabilities, ensures that messages resonate more with the prioritized population, and addresses these barriers. Client-centered service provision requires mutual respect, which can be difficult in the unequal power dynamic that is often present in a clinical setting. Counseling techniques that emphasize the importance of active listening, acknowledge the client's experience, seeks to understand, uses the client's language, and reserves judgment are the keys to addressing those power imbalances. Because providers are often unaware of their own biases, providing opportunities to reflect on them is the first step to discovering how to break down,

mitigate, or work around prejudice that can negatively influence client/provider interaction.

More information about the SHARP Program (<http://www.aidsalliance.org/our-impact/the-sharp-programme>)

Long-Acting Reversible Contraceptives Materials
(<http://healthcommcapacity.org/new-materials-help-providers-counsel-young-women-benefits-larcs/>)

Health Care Improvement Project. November 2011. *Cultural Sensitivity Builds Confidence in Maternal and Neonatal Health Services in Huehuetenango Guatemala*. Washington DC: USAID. (http://www.urchs.com/sites/default/files/Guatemala_Cultural_sensitivity_maternal-neonatal_services_Nov11.pdf)

Health Initiatives for the Private Sector. July 2008. *Effective Interpersonal Communication: A Handbook for Healthcare Providers*. Washington DC: USAID. (http://ccp.jhu.edu/documents/EffectiveInterpersonalCommunication_HandbookforProviders_0.pdf)

Murphy E. and C. Steele. 2000. *Client-Provider Interactions in Family Planning Services: Guidance from Research and Program Experience*. Washington DC: USAID. (<https://www.k4health.org/sites/default/files/vol2.pdf>)

PATH. July 1999. *Improving Interactions with Clients: A Key to High-Quality Services*. Seattle, Washington: USAID. (https://www.path.org/publications/files/eol17_2.pdf)

Appendix K – Bangladesh: Behavioral Maintenance Follow-Up

When a client's health status changes (for the good, such as with a planned pregnancy, or for the worse, such as being diagnosed with diabetes), the person often is highly motivated to make changes in their life and may succeed in adopting a new behavior. But daily life comes with myriad challenges that complicate clients' ability to sustain behavior change.

Challenge

Motivating clients to start healthy behaviors is a necessary first step toward achieving positive health outcomes. However, it is difficult to maintain those initial gains over time. Chronic conditions such as tuberculosis (TB) or diabetes require vigilance and strict adherence to a treatment regimen, but clients often stop taking drugs or continue eating sugary foods. The rise in drug resistance further demonstrates that people don't regularly complete their prescribed courses of treatment.

Research shows that between 30 and 70 percent of clients do not adhere effectively to treatment recommendations. Non-adherence to difficult behavioral recommendations, such as smoking cessation or following a restrictive diet, **more than 80 percent of patients** (<http://www.ncbi.nlm.nih.gov/books/NBK43749/>). The reasons are varied: providers may confuse the client with unclear instructions, or clients may not fully appreciate the consequences of not maintaining behaviors, or they may not believe that they can follow the behavior change or regimen as instructed. Some behavioral changes interfere with daily activities, such as medications that require multiple doses each day or those with special instructions (e.g., "take with food"). Side effects of treatment can also cause embarrassment. Families or communities may not maintain their support of behavior change, finding the changes uncomfortable or inconvenient. Stigma, discrimination, and social norms also strongly influence behaviors. Illnesses such as TB, HIV, and cancer all have social stigma attached to them, so patients may not want to be open about their condition, complicating behavior changes or behavioral maintenance.



Chronic disease management also challenges overburdened health systems. It is important to monitor chronic conditions, but service providers may struggle to fully engage in managing stable clients when crises or emergencies arise.

Response

Service communication supports long-term behavior change through a number of strategies and tactics that encourage continued adherence to changed behaviors. These can include tools such as SMS prompts or reminder calls for daily medications and client support group meetings.

Ongoing counseling can provide clinical support to clients, while community-based initiatives (e.g., support groups or clubs) encourage clients to overcome challenges and have been demonstrated to encourage adherence. Social and behavior change communication (SBCC) at the community level can also reinforce healthy behaviors such as correct and consistent condom use (to prevent HIV, other sexually transmitted infections, and unwanted pregnancy) or bednet repair and maintenance to prevent malaria.

Increasingly, information and communication technology makes it possible to reach target audiences instantaneously and privately. Hotlines, chat rooms, and SMS can quickly answer questions, eliminating the need for a visit to the facility. “Push” messages that are sent unprompted can provide information and remind clients of important behaviors, such as taking medication or keeping a medical appointment. A **2015 Cochrane review of mHealth** in family planning concluded that “evidence indicates that a series of voice messages and counselor support can improve contraception amongst women seeking abortion services not wanting to get pregnant again at the current time, and data suggest that daily educational text messages can improve continued use of the contraceptive pill”

(<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011159.pub2/abstract;jsessionid=ECEA91F832E56A8D7CFB270C695DCD5F.f01t02>). An earlier **review of text messaging and antiretroviral therapy (ART) adherence** noted that “Weekly mobile phone text messages to patients on ART can help them to take their medication every day. It can also help to reduce the amount of HIV in their bloodstream” (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009756/full>).

Case Study – Aponjon in Bangladesh

Challenge

Since the 1990s, Bangladesh has made great strides to reduce maternal and infant mortality, reducing maternal mortality ratio from 574 to 194 between 1990 and 2010. But gaps remain, particularly for poor women. In 2011, only 20 percent of women were attending the recommended four prenatal visits and almost half of pregnant women had anemia. Among women in the poorest quintile, 71 percent had their first child before age 18 and only 9 percent delivered with a medically trained provider. Meanwhile, trained providers were scarce, with just **3 doctors and 2.8 nurses for every 10,000**



Bangladeshis (<http://siteresources.worldbank.org/INTPRH/Resources/376374-1303736328719/Bangladesh42111web.pdf>).

Response

Whereas 55 of every 100 people have access to health services in Bangladesh, 64 out of 100 Bangladeshis are mobile phone subscribers. This high-level mobile phone penetration allowed the Mobile Alliance for Maternal Health Action (MAMA) to use mobile phone technology to reach pregnant women and new mothers with maternal and child health education. MAMA was a public-private partnership launched in May 2011 by USAID and Johnson & Johnson that operated in India, Bangladesh and South Africa. In Bangladesh, the not-for-profit social enterprise Dnet initiated the service and continues to run the initiative, known as Aponjon (“Dear One” in Bangla).

Aponjon is a subscriber service that targets expecting and new mothers and their guardians (husbands, mothers-in-law, and other family members) to communicate important health information about all stages of pregnancy and a child’s first year. Pregnant women, new mothers, and their families are recruited to join and pay a small fee (the service is free for poorer households). After registration, Aponjon delivers SMS or voice messages twice a week to pregnant women and delivers a

weekly message to a caregiver. These messages counter common misconceptions, highlight potential health dangers and warning signs, locate nearby healthcare services, and highlight the benefits of family planning. The messages are tailored to the stage of pregnancy or the child's age and, depending on a subscriber's location in an urban or rural setting, different types of messages are sent, contextual to subscriber's surroundings.

Messages use different formats to convey information, with messages delivered by an engaging female doctor character, "Daktar Apa," who is seen as a trusted source of health information for women. Voice messages use a dramatic and engaging format, featuring local actors playing the roles of doctors, women, and families discussing issues like the importance of iron-rich food and reminding pregnant woman about medical checkups. Text messages communicate information about medical emergencies and warning signs during pregnancy.

After a successful pilot in four districts, Aponjon began scaling up, expanding to more than 35 districts in Bangladesh in 2012. In 2013, Aponjon introduced a hotline that allowed doctors to give advice to registered mothers and family members. The mobile app, Aponjon Shogorbha (Pregnancy), which has been developed to reach mothers with smartphones, provides a more comprehensive platform for expecting and new mothers to learn about prenatal and neonatal health (available on [Google Play](#), in the [Apple App Store](#) and [Windows Phone App Store](#)). The app helps women monitor their pregnancies, estimating due dates, monitoring weight gain, and keeping track of appointments and reminders. The app even suggests healthy menus for pregnant women, allowing them to create healthy menus that cover calorie requirements, and describes how the baby is developing during pregnancy.

Aponjon promotes its services through branded buses, information, education, and communication materials, and community events such as health fairs.

Results

In 2016, four years since the pilot, Aponjon had reached more than 1.5 million subscribers.

A [quantitative evaluation conducted in September 2015](#) found that women who participated in Aponjon attend the recommended number of antenatal check-ups

at rates more than three times the national average (<http://www.tractionproject.org/resources/key-findings-mama-study-traction-supported-study-conducted-international-center-diarrheal>). These same women are more than twice as likely to give birth in a health facility. Results also indicated that respondents who had used Aponjon for a minimum of 6 months, received at least three messages per month, and carefully listened to most of the messages not only showed increased knowledge, but also were more likely to adopt good maternal and newborn healthcare practices.

Aponjon has also launched an app targeting adolescents with sexual and reproductive health information, as well as a hotline and web chat. The app also engages caregivers by allowing them to monitor the information Aponjon provides to their adolescents.

Application

Mobile technology is one strategy that responds to a number of health maintenance challenges, automating reminders and supporting those who are tasked with maintaining specific health behaviors. mHealth provides more interaction than the standard flipchart and prompts providers to touch on all important points, and can assist with supportive supervision by speeding data collection and analysis and providing supervisory job aids.

mHealth shows promises for reducing service providers' workload and improving health outcomes. The possibility of anonymity can help reach hidden, sensitive, or otherwise hard-to-reach populations with information tailored to different audiences.

ADDITIONAL RESOURCES

mHealth Evidence Website (<https://www.mhealthevidence.org/>)

HIP. **mHealth: Mobile technology to strengthen family planning programs.**

Mobile for Reproductive Health (m4RH)

(https://www.fphighimpactpractices.org/sites/fphips/files/hip_mhealth_brief.pdf)

Global Health Learning Center. **mHealth Basics: Introduction to Mobile**

Technology for Health. (<https://www.globalhealthlearning.org/course/mhealth-basics-introduction-mobile-technology-health>)

Appendix L – Uganda: Coordination Challenges

Challenge

Service communication activities often require partnership and coordination. As described in the [coordination section](http://sbccimplementationkits.org/service-communication/service-communication-implementation-kit/operational-considerations/coordinate-demand-side-and-supply-side-activities/) (<http://sbccimplementationkits.org/service-communication/service-communication-implementation-kit/operational-considerations/coordinate-demand-side-and-supply-side-activities/>), often a social and behavior change communication (SBCC) organization collaborates with a service delivery organization to develop communication that will contribute to improving health outcomes. Coordination has to occur before service delivery to generate demand for services, during service delivery to ensure that supply/services meet demand and that messages are harmonized, and after service delivery to support behavioral maintenance when clients are out of the clinical environment.

Response

With most productive partnerships, coordination among actors in service communication should leverage the comparative advantages of each partner, expanding their scope and reach. Formal arrangements such as memoranda of understanding and coordination mechanisms such as regular planning meetings operationalize the partnership and clarify roles and responsibilities. Joint planning and execution is of particular importance for campaign-style communication efforts and multi-year campaigns.

Coordination of service communication requires participatory processes that include intended populations in strategy development, implementation, and monitoring and evaluation (M&E). This will ensure that messages are well understood (including the rationale for sequencing and selection of channels), that activities are collaboratively planned and executed, and that monitoring allows partners to adjust activities and messages based on field experience. Joint evaluation can document the impact/relationship/influence of communication on service delivery.

Case Study: Stop Malaria Project – Uganda

Challenge

Due to high rates of malaria and a lack of affordable testing facilities, health programs in Uganda have told providers and caregivers to treat all fevers as malaria for more than a decade. With uptake of prevention measures such as indoor residual spraying and long-lasting insecticidal nets, malaria incidence has dropped, but presumptive treatment continues. This has made over-diagnosis of malaria an increasing concern. The 2011 Demographic and Health Survey showed that only 26 percent of children under 5 with fever were tested for malaria, while 46 percent received treatment with artemisinin combination therapy (ACT). Ninety-six percent of those who tested positive for malaria received an anti-malarial, but so did 48 percent of those who tested negative. This means that frontline antimalarial drugs (ACTs) were being over-prescribed, resulting in stock-outs for those who actually needed the drugs. Unnecessary ACT also risks creating resistance to artemisinin-based treatments – already the case with quinine-based treatment.



Identifying the true cause of fever could lead to more effective treatment and ultimately better health outcomes. In 2012, the Government of Uganda adopted World Health Organization guidelines recommending that all individuals exhibiting malaria symptoms be tested and that only those who test positive receive malaria treatment. The National Malaria Strategic Plan 2011-2015 aimed to ensure that 90 percent of all suspected malaria cases in Uganda are tested before treatment is initiated.

Unfortunately, many providers continue to rely on their own clinical judgment and experience rather than on diagnostic tests, and treatment is often given to patients with negative test results. Providers' reasons range from distrust of test results, lack of confidence in diagnosing and treating non-malaria fevers, and perceived or

actual patient demand for malaria medicine, despite test results. Qualitative research has suggested a need for clear guidelines, a supportive environment, trust in the capacity of the laboratory staff or equipment, and the skills to manage fevers and navigate patient expectations to ensure the adoption of parasite-based treatment.

Response

The USAID-funded Stop Malaria Project (SMP), led by Johns Hopkins Center for Communication Programs (CCP), collaborated with the Ugandan government and multiple health partners to design and execute the “Test and Treat” campaign. The campaign sought to 1) build trust in malaria test results among clients and health providers; 2) increase the proportion of clients with fevers who are treated appropriately; and 3) encourage community members to get children under 5 tested for malaria before treatment. The campaign was rolled out in 24 health districts where malaria is highly endemic.

The campaign targeted caregivers of children under 5 and clinical public health workers with the slogan, “*Don’t Guess, First Test,*” which promoted two behaviors: 1) all individuals exhibiting symptoms of malaria should get a malaria test, and 2) only those who test positive for malaria should receive treatment for malaria. Individuals who receive a negative test result for malaria should try to identify and treat the actual source of their symptoms.

Activities carried out during this campaign included:

- Mass media – Posters, billboards and radio spots to reach a large proportion of the intended audiences.
- Training and support supervision – Health providers were trained to improve their skills in managing fevers and communicating with caregivers about the importance of testing and adherence to test results. Training was reinforced by support supervision visits.
- Interpersonal communication – Group health education talks and one-on-one discussions between caregivers and Village Health Team members or other health providers gave caregivers more opportunities to learn about and discuss the new recommendations.

The Test and Treat campaign built on an existing campaign that promoted testing in Uganda. The “Power of Day One” campaign, implemented by the AFFORD Project for a year before this campaign, promoted testing and treatment for malaria within 24 hours of fever onset. The Power of Day One campaign contributed to increased uptake of ACT and rapid diagnostic testing in private sector health facilities, pharmacies and drug shops in four districts, which were part of the 24 districts covered by SMP.

- The Ministry of Health’s National Malaria Control Programme (NMCP) provided overall direction for the campaign. In addition to advising the partners on the Ministry’s strategic areas of interest, the NMCP helped ensure that diagnostic commodities were available to public health facilities in the participating districts. District health officials were positioned as master trainers to train clinical staff in their regions and provide supportive supervision in the rollout of the new protocol.
- As the lead implementing partner for SMP, CCP provided technical leadership for the design, implementation and M&E of the communication strategy
- Malaria Consortium (an SMP partner) designed and conducted provider training, developed training materials (intermittent parasite clearance [IPC] guides for national and district trainers), provider workbooks, a checklist for diagnosis of fever among children under 5 and a continuing medical education guide. Malaria Consortium also participated in support supervisory visits to participating health facilities.
- Mango Tree developed a flipchart for providers to use during patient counseling.
- Uganda Health Marketing Group and their contracted advertising agencies led the design, production and placement of media materials, including posters, billboards and radio spots. Pretesting was done in collaboration with SMP and NMCP. Uganda Health Marketing Group also led training of private-sector providers in diagnostic capacity, and led rollout of the campaign in private-sector facilities in six districts.
- World Vision integrated the Test and Treat messages in its distance radio learning program for village health teams, which are made up of community volunteers who provide basic health education and referrals for services.

Results

The combination of a designated coordinator, clear guidelines, access to tests and ACTs, the promotion of testing and appropriate treatment to providers and caregivers, and efforts to increase providers' ability to manage febrile cases and communicate effectively with caregivers all contributed to the campaign's success.

The evaluation of the campaign found a demonstrated a shift in provider practices. Providers with any exposure to the campaign were more likely to test all children who reported with fever (91-97 percent vs. 81 percent) and were less reliant on clinical diagnosis. Providers who were trained and exposed to the media campaign were more likely to conduct a differential diagnosis (86 percent vs. 76 percent) and less likely to prescribe antimalarial drugs for children with fever who tested negative for malaria (15–25 percent vs. 37 percent). Finally, providers who received clinical training that included IPC and counseling skills were more likely to tell caregivers that antimalarial treatment was not necessary after a negative test result (80 percent vs. 50 percent) and more likely to provide alternative diagnosis (86 percent vs. 76 percent). The campaign also improved availability and stocking of malaria drugs. Because service providers only treat when test results are positive, drugs are available for people who actually have malaria.

Application

Coordination is crucial when introducing new technology or services that require a shift in provider and client behavior. As the national governing bodies, the Ministry of Health is the appropriate body to establish protocols and policies and to be responsible for training public health sector staff. Development partners can contribute by supporting training and education and generating demand through communication and social mobilization. Civil society's role is often to mobilize communities and advocate for equity, accessibility and appropriateness of services.

Appendix M – Nigeria: Service Communication Strategy in Action

Nigerian Urban Reproductive Health Initiative

This case study illustrates how the elements of service communication can be applied in a real-world situation, and how use of social and behavior change communication (SBCC) approaches can significantly improve access, uptake and quality of health services, in turn leading to better health outcomes. The Nigerian Urban Reproductive Health Initiative (NURHI) applied best practices in SBCC throughout the stages of service delivery to revitalize Nigeria’s family planning program in urban areas. The program sought to gain maximum insight about its intended audiences and developed an appealing branded campaign that shared the functional and emotional benefits of family planning. The project developed the skills of public and private sector providers to ensure that clients understood benefits of different contraceptive methods, and conducted mobile outreach to reduce barriers to access. The project also worked to create a supportive environment that encouraged households and communities to discuss family planning openly, enabling more individuals to explore the benefits of family planning, identify the best method for them and sustain its use over time.

About NURHI

NURHI is funded by the Bill & Melinda Gates Foundation and managed by Johns Hopkins Center for Communication Programs (CCP). The Association for Reproductive and Family Health and Centre for Communication Programs, Nigeria are key partners, along with collaborating organizations such as the African Radio Drama Association, the Health Reform Foundation of Nigeria, Advocacy Nigeria, Development Communications Network, the Futures Institute and Marie Stopes International Nigeria.

The project was designed to assist the Nigerian government in revitalizing its family planning program and increase the contraceptive prevalence rate by 20 percentage points. NURHI focused its efforts on promoting contraceptive methods for birth spacing and limiting births, with a particular aim of increasing access to family

planning among the urban poor. The first phase of the project ran from 2009 to 2014 in six urban centers: Abuja, Benin City, Ibadan, Ilorin, Kaduna and Zaria.

NURHI originally had five objectives:

1. Develop cost-effective interventions for integrating high-quality family planning into maternal and newborn health, HIV and AIDS, postpartum, and post-abortion care programs
2. Improve the quality of family planning services for the urban poor, emphasizing high-volume clinical settings
3. Test novel public-private partnerships and innovative private-sector approaches to increase access to and use of family planning by the urban poor
4. Develop interventions for creating demand for and sustaining the use of contraceptives among marginalized urban populations
5. Increase funding and financial mechanisms and a supportive policy environment for ensuring access to family planning supplies and services for the urban poor

A sixth objective was added in 2012:

6. Identify potential “gateway behaviors” and test the effect of interventions designed to increase these behaviors and their downstream impact.

Challenge¹

One in every six Africans is Nigerian. As the continent’s most populous country, Nigeria is also experiencing a “youth bulge,” with more than half of the population under 24 years old. This is due in part to the country’s high fertility. On average, a Nigerian woman has six children, placing the country’s birth rate at 12th highest in the world. Compounding this situation, Nigeria’s poverty and health statistics are among the worst in Africa. When NURHI began in 2009, the World Bank estimated

¹ Statistics in this section are from <https://www.cia.gov/library/publications/the-world-factbook/fields/2212.html> and <http://datatopics.worldbank.org/hnp/HNPDash.aspx>.

that 83 million Nigerians (62 percent of the population) lived on less than \$1.90 per day, and infant and maternal mortality rates were alarmingly high (85 deaths per 1,000 live births, and an adjusted maternal mortality ratio of 610 per 100,000 live births, as of 2010).

Gateway Behaviors Study

There seem to be unique moments in time when individuals are particularly receptive to new information and motivated to make changes. NURHI's Gateway Behaviors Study used formative research that identified two gateway behaviors – completing at least four antenatal care visits during pregnancy and interpersonal communication on family health matters – that influence other health behaviors, such as family planning, exclusive breastfeeding and immunization. Piloted in Ilorin South from September 2013 to December 2014, the study used SBCC and social mobilization to engage pregnant women, their partners and their mothers-in-law. The project created profiles for each intended audience and leveraged key life events, such as naming ceremonies and weddings, as gateway moments to promote antenatal care and communication about family health matters. Advocacy and provider training ensured services were welcoming and competent. Registration of pregnant women in the pilot area increased substantially as a result of these interventions.

Nigeria is also increasingly urban. Estimates place some 48 percent of Nigerians in urban environments, with the rate of urbanization at just under 5 percent. There are at least 10 cities with more than 1 million residents, and 15 percent of the population lives in the country's six largest cities. Poverty and slum conditions pose health threats to Nigeria's fast-growing urban centers. More than 51 percent of urban dwellers live below the poverty line, and many lack adequate housing, sanitation, and waste management.

Despite a thriving family planning program in the 1980s and early 1990s, Nigeria suffered from changing donor priorities and funding. This contributed to stagnating trends in fertility, contraceptive use, and method mix over the past 10 years. In 2009, with contraceptive prevalence at only 10 percent, a total fertility rate of 5.7, and unmet need at 20 percent, there was a pressing need to reinvigorate family planning efforts at national, state, and city levels. Meanwhile, policies and programs

remained mostly on paper. There were a few national working groups focused on policy implementation, but family planning received little attention at state and local levels. Consequently, the family planning program was largely funded by external donors, the health system paid little attention to family planning, and many journalists and local leaders were vocally opposed to family planning. Unsurprisingly, government health facilities were poorly staffed, minimally equipped, and riddled with contraceptive stock-outs. Many couples obtained family planning services from proprietary and patent medicine vendors (PPMV), who can only dispense condoms and refill oral contraceptives to current users or pharmacists. Access to implants and IUDs were restricted to a few hospitals.

Response

NURHI's SBCC approaches were employed throughout the three stages of service delivery, with specific roles in each stage:

- **Before** services were delivered by raising general awareness about family planning and available services, addressing community and social norms, and reviving demand for family planning
- **During** services by ensuring that all service providers (clinical and non-clinical, private and public sector) were able to provide high-quality family planning counseling and services and increasing access through mobile outreach
- **After** services by promoting open discussion about family planning within couples and peer groups and soliciting the support of community leaders and local government to sustain commitment to family planning efforts

NURHI's approach to improving access to and quality of family planning services led with demand generation efforts that applied a "consumer lens" to communicate about and deliver services. The hypothesis was that creating demand would, in turn, drive supply, thereby creating a sustainable response. As the graphic below illustrates, the project's approaches to demand generation and service delivery mutually reinforced one another.



NURHI systematically used research, consumer feedback (through pre-testing) and monitoring data to revise and refine its messages.

Before: Bringing Clients to Services

To create interest and demand for family planning services, NURHI used the situation analysis and audience insight to design a multi-phased, multi-channel demand generation strategy built around a highly visible umbrella brand, “**Get It Together.**” (<http://www.nurhitoolkit.org/program-areas/demand-generation/get-it-together-campaign#.V1WBFfkrKhc>) For more information on how to develop a brand, see [How-To Create a Brand Strategy Part 2](#).

Step 1: Segmenting, Prioritizing, and Profiling the Intended Audience

In assessing the family planning situation, NURHI used qualitative and quantitative research, including focus group discussions, a [Baseline Household Survey](http://www.nurhitoolkit.org/program-areas/rme/formative-research#.V1WDJvkrKhc) (<http://www.nurhitoolkit.org/program-areas/rme/formative-research#.V1WDJvkrKhc>), secondary analysis of the 2008 Nigerian Demographic and Health Survey and a social mapping exercise to learn about community members’ attitudes toward family planning services and identify points of entry for social mobilization activities. NURHI used the concept of ideation to identify beliefs, emotions and



behaviors that contributed to individual family planning use and worked to influence those factors.

In 2010, NURHI held a participatory design workshop to analyze research findings and draft the demand generation strategy.

Step 2: Draft a Demand Generation Strategy

The demand strategy linked closely with NURHI service delivery, advocacy and public-private partnership activities. In its branded media campaign (see below), NURHI used a variety of mass media channels, community-level activities and referrals for family planning services led by social mobilizers, and an “entertainment-education” radio drama featuring satisfied users who modeled family planning use and promoted services.

Step 3: Design and Test Materials and Interventions

Branding: NURHI worked with an advertising agency to develop a campaign brand and materials based on audience insights. A **creative brief** guided the agency to develop a campaign targeting 15- to 45-year-old women and 20- to 50-year-old men living in slums (http://www.nurhitoolkit.org/sites/default/files/tracked_files/Mass Media Creative Brief.pdf). The brand logo, finalized after pre-testing, included a tagline (“Know. Talk. Go.”) that encouraged the target audience to know about family planning, talk with partners about family planning, and go for family planning services. NURHI also worked with the agency to produce a package of branded radio and television spots and print materials.

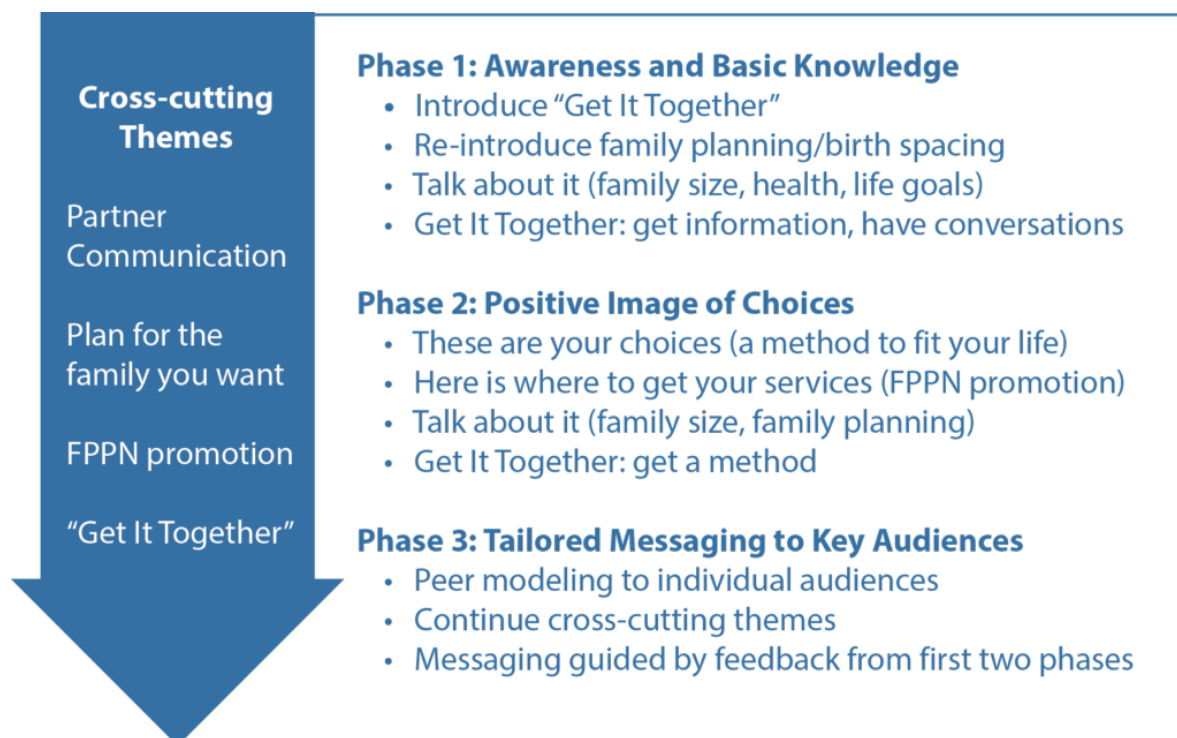
Community mobilization: NURHI and partner Centre for Communication Programs, Nigeria designed a **social mobilization strategy** that engages young (18- to 35-year-old) barbers, tailors, hairdressers and motorcycle delivery people to discuss family planning with individuals and groups (<http://www.nurhitoolkit.org/node/145#.V1WEqvkrKhc>).

Entertainment-education: NURHI and partner African Radio Drama Association produced three seasons of a weekly radio program in each target city. See a **step-by-step narrative of the radio design process:** http://www.nurhitoolkit.org/program-areas/demand-generation/radio-drama-.V1WFW_krKhc.

The illustration below depicts how the campaign rolled out messages in three phases. The first phase built awareness and introduced the topic of family planning among targeted communities; the second phase introduced the range of modern contraceptive options to motivate informed choice; and the third phase encouraged behavior change through tailored messages for specific audience segments.

Reaching Urban Youth

The **Urban Adolescent SBCC Implementation Kit** (I-Kit) provides a selection of essential elements and tools to guide the creation or strengthening of sexual and reproductive health SBCC programs for urban adolescents aged 10 to 19. The I-Kit is designed to teach these essential SBCC elements and includes worksheets to illustrate each element and facilitate practical application (<http://sbccimplementationkits.org/urban-youth/>).



Step 4: Campaign Launch

NURHI launched Get It Together in four cities in October 2011, with television and radio spots and posters in high-traffic areas. Service providers received branded job aids, print materials, and promotional items. Social mobilizers also received

branded promotional and educational materials. Trained mobilizers facilitated radio listening groups, conducted visibility parades, leveraged key life events for points of discussion, spearheaded neighborhood campaigns and referred clients to Family Planning Providers Network (FPPN) services with Go Referral Cards. After six months of the campaign, radio programs began weekly broadcasts. Each program included a serial drama episode, interviews, music, and a weekly quiz, plus a live call-in session with a family planning expert. Listeners could win prizes by answering weekly questions through text messaging.

During: Client-Provider Challenges

NURHI's service delivery strategy focused on facilities with high-volume services – defined as public or private health facilities with the highest volumes of antenatal, delivery, family planning and immunization clients. Most were tertiary or teaching hospitals, secondary facilities or general hospitals, military hospitals, and hospitals that provide free maternity services. Research showed that pharmacies and PPMVs were additional points of access for family planning services and information, so NURHI developed criteria to select pharmacies and PPMVs, including their willingness to join the [FPPN \(http://www.nurhitoolkit.org/node/15\)](http://www.nurhitoolkit.org/node/15).

NURHI adopted three approaches to address the challenges of service delivery.

- 1. Improving the quality and accessibility of services:** NURHI provided robust training for service providers in family planning counseling and IUD and implant insertion and services. The project also worked at facility level to improve contraceptive logistics and management systems. Training included in-person, on-site clinical training, on-the-job training for counseling, distance learning via mobile platforms, and supportive supervisory visits. NURHI used mobile teams of service providers from Marie Stopes International Nigeria to reach additional clients. NURHI also helped upgrade services with additional equipment, using a **“clinic makeover” approach** to rapidly make each site more inviting and pleasant for clients (<http://www.nurhitoolkit.org/program-areas/service-delivery/72-hour-clinic-make-over#.V1WGGvkrKhc>).
- 2. Integrating family planning with existing maternal, neonatal, and child health and HIV services:** NURHI developed an integration strategy , provided

onsite training for high-volume service providers in family planning counseling and strongly promoted postpartum IUD services. Because these services were already at capacity, NURHI created an active referral program to route clients to dedicated FP services.

- 3. Strengthening relationships and referrals between public and private sector family planning providers:** NURHI enhanced referrals systems to ensure that clients who need family planning services have access to them. Social mobilizers received branded Go cards to refer community members to high-volume services sites and allow service providers to know who referred the client, gave mobilizers the ability to follow up with clients and enabled the project to collect data for analysis. NURHI also used existing referral mechanisms to track clients when they were sent to a different facility within the network. The referral strategy articulated roles and responsibilities among service providers, facility management, community mobilizers, NGOs and NURHI staff.

Engaging Private Providers (<http://www.nurhitoolkit.org/program-areas/service-delivery/public-private-partnerships/ffpn/>)

NURHI created the FPPN to establish a platform where family planning providers could interact and work together to increase access, referrals, and family planning service quality. This public-private initiative supported clinical and non-clinical service providers to improve contraceptive logistics management, increase the quality of family planning service delivery through training, strengthen referrals between service delivery points, and use branding and promotion to increase access to and uptake of family planning services. In 2014, the FPPN became the Sustainable Family Planning Providers Association and developed a strategic plan, through 2018, with goals to increase utilization, expand and sustain the family planning method mix, improve service quality, and win support from local leaders.

After: Maintaining Behavior

NURHI's advocacy strategy focused at the state and local levels to engage local government officials, community leaders and the media to support family planning efforts. Partners with expertise in local advocacy assisted the project in needs

assessment and identified stakeholders to participate in advocacy efforts. NURHI's Advocacy Core Groups assembled leaders from each city to identify high-priority policy issues and develop advocacy plans to address them. NURHI facilitated the creation of national and site-specific **advocacy kits** with position papers, policy briefs and fact sheets to support local advocacy efforts (<http://www.nurhitoolkit.org/program-areas/advocacy/advocacy-tools/advocacy-kits#.V1WGovkrKhc>).

Futures Institute created tools to stimulate dialogue on the impact of population on the environment, social services and economic development. Advocates were trained to use a number of advocacy tools (Spitfire training materials, budget projections and tracking) to push local governments to prioritize family planning in development plans and budgets. NURHI also targeted media outlets using its **media advocacy strategy** (<http://www.nurhitoolkit.org/program-areas/advocacy/media-advocacy#.V1WGsfkrKhc>) to enhance the quality and quantity of media coverage of maternal and child health issues, with a focus on family planning.

NURHI identified and engaged community leaders and community groups to increase their support of and involvement with family planning, providing them with messages and strategies to address health concerns and the fear of side effects. The project also formed interfaith forums in each city to bring together religious leaders once a year to collaboratively develop messages and strategies to increase family planning use in their communities.

Service communication and behavioral maintenance was further supported through the Get It Together campaign's focus on dispelling myths and promoting open discussion about family planning among couples and peer groups, making the use of family planning more acceptable and desirable.

Coordination

A complex array of partners contributed to NURHI's success, working under varied partnership models—formal partnerships, contracting and procurement, creation of new platforms and leveraging of existing structures. These partnerships allowed NURHI to expand the scope and scale of its activities. Clear roles and

responsibilities in planning, implementation, and M&E ensured that all partners understood expectations about their contributions to the project. NURHI supported national, state, and local government structures to set the strategic direction of activities and monitor progress toward goals. The FPPN provided a platform to engage the service providers, particularly those in the private sector.

NURHI employed an advocacy and behavior change officer to monitor and coordinate the mass media radio program and social mobilization activities through regular meetings with partners, radio program monitoring, and tracking referrals by social mobilizers for family planning services.

Results

NURHI showed immediate results and continuous progress. The **midterm assessment survey** conducted after one year of implementation showed that 83 percent of men and women knew about the NURHI ‘Get it Together’ campaign (https://www.urbanreproductivehealth.org/sites/mle/files/nurhi_baseline_household_survey.pdf). The NURHI **midterm survey results** showed an increase of 3–15 percent in contraceptive prevalence rates in the four initial cities in less than two years. The data also revealed that the proportion of women who intend to use family planning increased from 7.5–10.2 percent (https://www.urbanreproductivehealth.org/sites/mle/files/nigeria_midterm_twp2_2013.pdf).

The 2013 National Demographic Health Survey showed an increase in family planning contraceptive prevalence rate in cities where NURHI operated.

Endline results showed significant increases in knowledge about family planning and increased contraceptive prevalence rates in every city where NURHI intervened (https://www.urbanreproductivehealth.org/sites/mle/files/mle_twp2-2015_nigeria.pdf), with significant increases in use of modern methods. These results demonstrate that the project was able to communicate effectively about family planning and motivate women to use modern methods.

Executive Summary table of key indicators at baseline and endline

Percent distribution of women for select key indicators, Nigeria 2010/2011, 2014

	Abuja		Benin City		Ibadan		Ilorin		Kaduna		Zaria	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Knowledge of FP (spontaneous)												
Any method	66.9	95.0	83.6	89.3	87.0	95.3	77.1	97.6	63.7	96.5	62.0	95.0
Modern method	65.4	94.5	82.6	88.1	86.4	94.6	76.6	97.3	63.3	96.0	61.6	94.2
No knowledge of modern method	34.6	5.5	17.4	11.9	13.6	5.4	23.4	2.7	36.7	4.0	38.4	5.8
Number	2126	1338	2512	1321	2928	1714	2449	1702	2850	1995	3279	2602
CPR among all women in union												
Modern method	32.2	40.4	23.3	32.7	33.5	45.9	27.0	34.5	19.9	30.5	5.9	24.0
Traditional method	11.7	11.4	17.4	19.8	13.3	15.5	8.9	19.9	6.6	10.4	2.5	8.2
No use	56.1	48.4	59.3	47.5	53.3	38.6	64.1	45.6	73.5	59.1	91.5	67.8
Number	1347	873	1293	762	1979	1229	1563	1217	1583	1302	2284	1981
Contraceptive method switching between baseline and endline												
	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline	Baseline→Endline
Adopted modern method	21.4	19.3	23.4	22.8	19.5	18.0						
Continued modern method	17.0	10.0	16.1	9.8	9.4	1.9						
Continued trad/nonuse	48.5	55.4	47.0	56.1	64.2	77.2						
Discontinued modern method	13.1	15.3	13.5	11.4	6.9	2.9						

Other results include establishing the FPPN as the Sustainable Family Planning Provider Association and increased budgetary support for family planning from state and local governments. Media reporting is now more pro-family planning, and national leaders are more vocally supportive of family planning. NURHI's channel analysis determined that radio and community mobilization activities were the best investments, in terms of cost effectiveness.

Next Steps

Phase II of the NURHI project commenced in October 2015. This five-year phase is being implemented at the state level in Lagos, Kaduna and Oyo. NURHI II continues to use the premise proven under NURHI I: that demand for family planning is a requirement for increased contraceptive use and that will lead to increased contraceptive supply and available services

ADDITIONAL RESOURCES

NURHI project website: www.nurhitoolkit.org

Measurement, Learning & Evaluation Project, Urban Reproductive Health Initiative: <https://www.urbanreproductivehealth.org/projects/nigeria>