



From Vision to Action:

Guidance for Implementing
the Circle of Care Model[©]

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Contact

Breakthrough ACTION
Johns Hopkins Center for Communication Programs
111 Market Place, Suite 310
Baltimore, MD 21202

Telephone: +1 410-659-6300

Email: info@breakthroughaction.org

Web: www.breakthroughactionandresearch.org

Acronyms

ANC	Antenatal care
ARV	Antiretroviral
CHW	Community health worker
CI	Confidence interval
FC+	Fistula Care <i>Plus</i>
FP	Family planning
HC4	HIV Response: Coordination, Community, Capacity, and Communication
HEW	Health extension worker
IMCH	Integrated maternal and child health
IVR	Interactive voice response
NGO	Non-Governmental Organization
PHC	Primary health care
PPFP	Postpartum family planning
PRACHAR	Promoting Change in Reproductive Behavior of Adolescents
PrEP	Pre-Exposure Prophylaxis
RMC	Respectful maternity care
RR	Relative risk
SBC	Social and behavior change
STI	Sexually transmitted infection
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision

About this Resource

This resource provides specific guidance for implementing the [Circle of Care Model®](#) and developing social and behavior change (SBC) for service delivery initiatives that influence attitudes and behaviors among clients and providers. For each stage along the continuum of care—before, during, and after services—this resource provides a list of sample activities, case studies, implementation tips, and selected indicators.

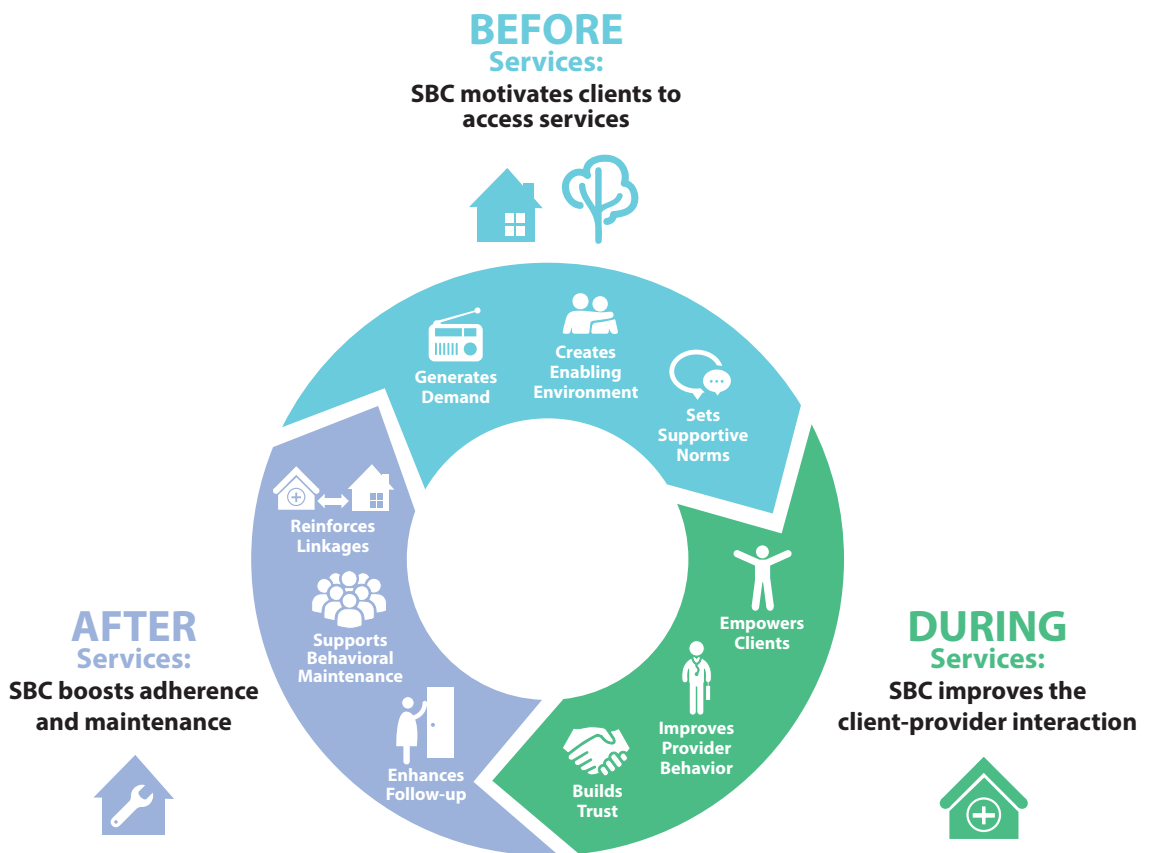
This implementation guidance is intended to be used by anyone working to improve service-related health outcomes, particularly in family planning (FP) and reproductive health. The assumption is that users of this resource have some understanding of SBC in service delivery, including the ability to [identify relevant determinants of behavior change](#) and [employ social and behavioral science theories and their constructs](#) to design effective initiatives.

Definition of Social and Behavior Change for Service Delivery

SBC for service delivery refers to using SBC processes and techniques to motivate and increase uptake and maintenance of health service-related behaviors among intended audiences. It uses a holistic model, the Circle of Care, to show how SBC can be applied across the service delivery continuum to improve health outcomes. SBC for service delivery is distinguished by its focus on service interactions: the use of SBC to motivate clients to access services (before services), to improve the client-provider interaction (during services), and to boost adherence and maintenance (after services). The concept includes considerations of social and cultural norms that impact service use (or non-use) and delivery, the physical environment in which services are delivered, and the communication that takes place between a client and provider.

Overview of the Circle of Care[®]

The Circle of Care Model[®] is a framework for understanding how SBC initiatives can be used along the service delivery continuum. It demonstrates how service delivery and SBC can strategically align to improve health outcomes. The model comprises three stages: **Before**, **During**, and **After** services. Each stage highlights three intermediate outcomes to which SBC contributes.



In the **Before Stage**, the goal is to capture the attention of potential clients and inspire them to access services while creating an environment that supports or enables service utilization. During this stage, SBC initiatives can help to generate demand for services, create an enabling environment, and set supportive norms to promote health seeking.

The **During Stage** refers to the point in the continuum when clients are actively accessing services, generally in a facility setting, as well as in outreach and mobile services. During this stage, SBC initiatives can be used to empower clients, improve provider behavior, and build trust between communities and health service providers.

In the **After Stage**, clients are often faced with either starting a new healthy behavior or remaining motivated to continue a healthy routine, such as treatment, daily medication, or change of diet. During this stage, SBC initiatives can be used to enhance follow-up, support behavioral maintenance, and reinforce linkages between clients and the health system.

Three key principles support the model:

1. **Segmenting, prioritizing, and profiling of key audiences**, which helps to understand the intended audience and learn about their specific needs, values, and barriers to change. Placing the needs, perspectives, and wants of both clients and providers at the forefront of program planning is the overarching principle that grounds the model.
2. **Effective coordination among SBC and service delivery partners**, which promotes common understanding regarding program planning, message development, approaches, and monitoring and evaluation.
3. **Addressing providers as a behavior change audience**, which ensures providers are seen as individuals who have needs, barriers, and motivations related to adopting desired behaviors related to their performance.

Operationalizing the Circle of Care Model[©]

The Before Stage:

Motivate Clients to
Access Services



Overview of the Stage

In the [Before Stage](#), the goal is to capture the attention of clients and inspire them to access services while creating an environment that supports or enables service utilization. During this stage, SBC initiatives can be used to do the following:

1. [Generate demand](#): Raise awareness of services, address knowledge gaps and misperceptions, and increase self-efficacy to access services
2. [Create an enabling environment](#): Support dialogue between communities and health providers to build mutual understanding, advocate, and mobilize leaders to allocate resources to promote service utilization and remove barriers
3. [Set supportive norms](#): Foster practices that promote health-seeking and social support for services by mobilizing communities to discuss health issues and influencing how and to whom clients talk about health; normalize the idea that “people like me” seek health care services

What Skills Are Needed at This Stage?

In the Before Stage, implementers need the skills to understand both their audience and the social and environmental factors that influence their health-seeking behaviors.

Specifically, implementers should have the skills to do the following:

- [Identify, segment, and profile audiences](#)
- [Determine audience needs, desires, barriers, and influencers](#)
- Understand the individual, social, structural, and environmental factors that may impact health behaviors (e.g., [social norms](#), [laws, policies, and regulations](#))
- Identify specific and reasonable behaviors to promote
- [Engage stakeholders](#) and [conduct community dialogues](#)
- [Tailor messages](#) and [select appropriate communication channels](#)

Sample Activities

In the Before Stage, practitioners should design initiatives that motivate clients to access services by generating demand, creating an enabling environment, and setting supportive norms. This section contains a list of sample activities and six more detailed activity descriptions.

When selecting Before Stage activities, implementers need to remember to:

- Choose activities that meet their audience's specific needs, values, and barriers to access
- Consider the evidence base before selecting activities (see the [Circle of Care Before Stage Brief](#) for evidence on effective interventions)
- Reach their audience through multiple channels and activities; single channel initiatives (e.g., print materials alone) are rarely effective
- Choose activities that fit with the project's budget and timeline test



Activities to Generate Demand

Creating demand for health services involves raising the intended audience's desire, perceived need, and ability to take action to improve their health and well-being.¹ [Studies have proven](#) that SBC has a significant impact on uptake of services both directly and indirectly by promoting and fostering dialogue to dispel myths and misconceptions about services and health topics, raising awareness of existing or new services, addressing knowledge gaps and perceptions of risks and benefits, and increasing self-efficacy to access services. Mass media campaigns and peer education programs are two demand-generation activities implementers can consider.

1. Krenn, S., Cobb, L. Babalola, S., Odeku, M., Kusemiju, B. Using behavior change communication to lead a comprehensive family planning program: the Nigerian Urban Reproductive Health Initiative. *Global Health Science Practice*. 2014; 2(4): 427-443.

Mass Media Campaigns

Mass media campaigns utilize tailored messages to communicate service benefits, advertise availability and location of services, address misinformation, and help individuals determine when to seek care. Mass media campaigns can both directly and indirectly increase demand for health services. For example, campaigns on WhatsApp, social media, television, and the radio can educate people about contraceptive options and the benefits of delaying and spacing births, spread awareness about local FP services, and promote positive gender norms that encourage shared household decision-making.

Is a Mass Media Campaign Right for Your Project?

Research shows that mass media campaigns have a positive impact on attitudes about FP, communication with others about FP, and use of modern contraceptives. This evidence also demonstrates that the cost effectiveness of such campaigns improves per person exposed. However, mass media campaigns may not be feasible given a project's mandate, available skill sets, or resources. If a project does not have the ability to consider a mass media campaign, implementers may want to identify other channels or trusted individuals the target audience turns to for information. Implementors can also consider partnering with projects that are producing mass media campaigns. See the [Business Case for investing in Social and Behavior Change for Family Planning](#) for more information.

Peer Education Programs

Peer education programs recruit individuals to promote health in their communities by educating and supporting their peers to engage in healthier practices. Peer educators can provide fellow community members with emotional support, help them navigate care and treatment, and educate them about health conditions and behaviors that may impact their health. For example, peer educators can improve HIV outcomes by increasing HIV knowledge and promoting protective behaviors within their peer group to reduce HIV transmission. A systematic review and meta-analysis of peer education HIV prevention programs in developing countries found that peer education interventions were significantly associated with increased HIV knowledge, increased condom use, and reduced sharing of equipment among injection drug users.²

2 Medley, A., Kennedy, C., O'Reilly, K., & Sweat, M. (2009). Effectiveness of peer education interventions for HIV prevention in developing countries: a systematic review and meta-analysis. *AIDS education and prevention: official publication of the International Society for AIDS Education*, 21(3), 181–206. <https://doi.org/10.1521/aeap.2009.21.3.181>



Activities to Create an Enabling Environment

An enabling environment includes many interrelated factors—socio-cultural values, policies, governance, and infrastructure—that are critical to the effectiveness and sustainability of service delivery programs. SBC can foster and support an enabling environment at the community, district, and national level to reduce barriers to accessing services. Initiating and hosting community dialogues and advocating with government officials are two activities that can help create an enabling environment.

Community Dialogues

Community dialogues are interactive and participatory processes that provide community members with the opportunity to share information, opinions, and ideas, and ideally reach some common understanding about a given set of issues. SBC practitioners can create a robust, enabling environment for health-seeking behavior by recruiting local community leaders to facilitate dialogues between community members and local health providers to build trust and mutual understanding.

Advocacy with Government Officials

Advocates can influence local or national government officials to adopt new service delivery technologies and remove policy barriers to accessing health services by producing tailored messages, pressing leaders to act to ensure availability of commodities and funding, and providing key evidence to support their desired outcomes. Advocates can reach government officials (i.e., their target audience) through media outlets, public events, and elevating research and evidence that supports investment in health programs and reducing barriers to accessing services. For example, to create an enabling environment for self-injection of the contraceptive Depot-medroxyprogesterone acetate, advocates can provide evidence of the feasibility of community-based distribution of injectables to promote policies that allow for task-shifting of injectables distribution.

Additional Sample Activities

- Engaging in human centered design with the target audience to identify their key needs, values, barriers, and other characteristics or circumstances that influence their health-seeking behavior. Programs can use this information to tailor demand generation activities for each audience segment.
- Partnering with community members and leaders to set collective goals for the SBC initiative.
- Amplifying and share testimonials from satisfied clients within their communities
- Using hotlines to link clients with health facilities and services
- Training community health workers (CHWs) to counsel on family planning options during home visits



Activities to Set Supportive Norms

Norms around a specific health issue or program refers to “the community’s beliefs and rules about how acceptable it is to talk about and participate in activities regarding the issue or program of interest.”³ Two types of norms influence behavior: injunctive norms (“doing what others think one should do”) and descriptive norms (“doing what others do”).⁴ SBC can foster supportive norms and practices that promote health-seeking behavior and social support for services by mobilizing communities to discuss health issues and influencing how and to whom clients talk about health, including family members, community members, and service providers.

Influence how and to whom clients talk about health

Implementers can influence how and to whom clients talk about health by identifying an audience’s key influencers and designing programs that work with these key influencers as a means of indirectly changing their audience’s behavior. For example, to improve maternal health, SBC practitioners may develop a community-based program to educate mothers-in-law or grandmothers via existing community groups and counsel them to encourage women in their family to seek maternal health services. Programs may also collect and promote testimonials from influencers about their support for a behavior or positive experience with a health service.

Encourage community dialogue and reflection through community theater

Encourage community dialogue and reflection through community theater: Implementers can work with community members to write and perform plays that promote supportive norms around a health issue in the community and initiate community dialogue and reflection. For example, a play to promote positive norms around FP could include characters like community leaders who support FP and husbands or mothers-in-law who discuss their attitudes about their wives or daughters-in-law using contraceptives. After various scenarios are presented, actors can invite audience members to provide feedback, re-enact scenes, or introduce new scenarios to act out and prompt discussion with other community members.

Additional Sample Activities

- Designing posters, brochures, pamphlets, and other printed materials that educate clients about health topics and available services; these materials need to be suitable for the target audience (i.e., in a widely-spoken language and at an accessible literacy level)

3. Figueroa, M., Kincaid, L., Rani, M. and Lewis, G. (2002). Communication for social change: an integrated model for measuring the process and its outcomes. Rockefeller Foundation and Johns Hopkins University Center for Communication Programs.

4. Mackie, G., Moneti, F., Shakya, H. and Denny, E. (2015). What are social norms? How are they measured? UNICEF and University of California, San Diego, Center on Global Justice. Retrieved on May 1, 2017 from: https://www.unicef.org/protection/files/4_09_30_Whole_What_are_Social_Norms.pdf

Before Stage Case Studies

Fistula Care *Plus*: Nigeria and Uganda

Fistula, a devastating maternal morbidity, can cause severe health and psychosocial consequences when left untreated. Program evidence and epidemiological estimates indicate many women with fistula have not reached fistula services and are not well-served by existing service delivery models. The USAID [Fistula Care Plus \(FC+\)](#) project implemented by EngenderHealth sought to mitigate barriers to fistula care, identified through formative research conducted with the Population Council.

As part of a comprehensive initiative to reduce barriers to fistula treatment, FC+ partnered with Viamo to introduce a free interactive voice response (IVR) hotline for fistula screening and referral in Nigeria and Uganda. IVR algorithms in the caller's chosen language screened for fistula and provided messages about how to get treatment. The hotline collected positively-screened callers' demographics, self-reported fistula etiology, and experienced barriers to care. Community agents followed up with positively-screened callers, linking them to a fistula diagnosis and treatment site and vouchers for free transportation. The hotline was advertised through community outreach, mass media, and at community sites and primary health care (PHC) facilities. The direct hotline approach addressed barriers including stigma that prevents many women with fistula symptoms attending community events, gatekeeping by family members hindering care-seeking, and provision of incomplete or inaccurate information about fistula at PHC facilities. The IVR interface ensured access to information was not hindered by widespread low literacy. The transportation vouchers addressed barriers related to poverty and rural residence.

Over a year of implementation, 566 women completed the IVR hotline screening in the intervention areas in Nigeria and Uganda. 73% of hotline callers screened positive, and an estimated 200 fistula cases were identified and linked to first time care through the intervention. This represents approximately 15% of the fistula cases in the intervention areas.



Source: Bellhouse, L. (2015). Clients after fistula repair in Sokoto, Nigeria. Maryam Abacha Women and Children's Hospital, Sokoto.

Promoting Change in Reproductive Behavior of Adolescents: India

The [Promoting Change in Reproductive Behavior of Adolescents \(PRACHAR\)](#) Project's objectives were to delay the age of marriage until 18 years (women) and 21 years (men), promote modern spacing methods of contraception, delay the first birth until the mother is 21 years old, and space the second and subsequent births by at least three years. PRACHAR was implemented over three phases using two different implementation models (non-governmental organization [NGO]-led and government-led) between July 2001 to August 2012.

PRACHAR engaged community members in three districts of the state of Bihar. Trusted and respected members of the local community delivered messages and information to adolescents, young married couples, parents, and other influential adult figures. These messages and information were in culturally sensitive forms and in language appropriate to local levels of education. In partnership with 30 local non-governmental implementing partners, Pathfinder conducted trainings, community group meetings, home visits, and events.

PRACHAR's original NGO-led model included behavior change elements and multiple overlapping communication channels and increased contraceptive use among young married couples, with sustained outcomes for four to eight years after project interventions ended. Several elements were critical to the effectiveness of PRACHAR, including use of a socioecological intervention model with emphasis on behavior change efforts; use of a gender-synchronized approach (targeting young men and women, both separately and together as newlyweds); and intensity of interventions calibrated to the life cycle of adolescents and youth. While the hybrid government-NGO model of PRACHAR implementation reached greater scale than the original NGO-led model, comparing results suggests a trade-off between reaching greater scale and overall effectiveness of interventions and sustained impacts.



Source: Vespia, M. (2017). Pinki Kumari, 25 years old, with her husband, Madan Kumar Verma, 30 years old. India.

HIV Response: Coordination, Community, Capacity and Communication: Eswatini

HIV Response: Coordination, Community, Capacity, and Communication (HC4) aimed to find a confidential and interactive way to reach men with tailored HIV messages as well as provide personalized recommendations for services. To achieve this, HC4 developed a tablet-based risk assessment, where men could answer questions about their specific behaviors and be provided with key information and recommended services based on their eligibility and need.

Trained community-based mobilizers and expert clients living with HIV offer men the self-administered questionnaire as part of HIV prevention sessions held in communities and workplaces. Questions identify risk behaviors, and screen for current HIV and voluntary medical male circumcision (VMMC) status. Each response solicits a tailored informational message. Once all responses are entered, an algorithm outlines recommended services and prompts men to decide which services they would like linkage support for. Services include HIV self-testing, antiretroviral treatment, VMMC, tuberculosis screening, STI screening, pre-exposure prophylaxis (PrEP), and condoms, as well as engagement in WhatsApp groups for further information. With consent, the mobilizer can immediately provide linkage support to the male for requested services. Further analysis also allows HC4 staff to identify men who are living with HIV but not linked to treatment for follow-up.

HC4 has found high acceptability among men reached to engage with the risk assessment. Between October 2019 and July 2020, a total of 11,872 men have been reached; 5,964 were linked to HIV services, including 4,696 HIV testing services, 1,148 VMMC, and 657 PrEP. The assessment also identified 6,852 men as already circumcised, and 248 men who self-identified as living with HIV but 53 (21%) who were not on treatment and were provided follow-up by HC4.



Source: Johns Hopkins Center for Communication Programs. Hc4 Project. (2018). Eswatini.

Before Stage Implementation Tips

- **Implementers should involve the audience in formative research, design, and implementation of the program** to ensure audience needs are met and increase community capacity to design and manage ongoing and future programs. Involving the audience can take many different forms depending on the project, context, timeline, and scale of the program (e.g., practitioners can train their audience to conduct formative research, include them in goal-setting for the program, or form fully-equal partnerships with communities where community partners are equally responsible for all aspects of program design, implementation, and evaluation). Projects need to pay special attention to ensuring that strategies developed are accessible to the audience (e.g., language used in any materials needs to match audience literacy levels, required technology needs to be available and usable, and required language interpreters need to be available).
- **Identify community needs and existing assets** and determine how to partner with existing organizations and/or individuals to guide and support implementation. Using an [asset-based approach](#) “allows community members to identify, support, and mobilize existing community resources to create a shared vision of change.”⁵
- **Set up coordination mechanisms** between service delivery and SBC partners at national and local levels to ensure that efforts are synchronized and working towards the same goals. For example, hold quarterly coordination meetings, establish joint work planning processes, or identify project liaisons to foster collaboration. The [Service Communication I-Kit](#) provides more information on coordination principles.
- **Consider gender norms** that influence whether and how clients seek care and determine how restrictive norms can be changed through partnership between SBC and service delivery programs. For example, SBC and service delivery partners can address barriers to men accessing services by using [gender-synchronized approaches](#) to shift perceptions of masculinity and healthcare seeking and by adapting intervention and health services approaches to better meet men’s needs. In the HC4 project, allowing men to self-administer the risk assessment provided an added layer of privacy and comfort while still offering critical information and recommendations.

5 Sharpe, P.A., Greaney, M.L., Lee, P.R., & Royce, S.W. (2000). Assets-oriented community assessment. *Public Health Reports*, 115(2/3), 205–211.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308712/pdf/pubhealthrep00022-0103.pdf>

Sample Before Stage Indicators

This section presents a small selection of illustrative indicators that practitioners can use to measure Before Stage activities. You can find these and other validated indicators in the [SBC for Family Planning Service Delivery Indicator Bank](#) and the [Family Planning and Reproductive Health Indicators Database](#).

For additional guidance, please refer to the [Twelve Recommended SBC Indicators for FP brief](#) and accompanying [Indicator Reference Sheets](#), developed by Breakthrough RESEARCH.

Table 1. Sample Before Stage Indicators

Indicator	Calculation
Percent of audience with a favorable (or unfavorable) attitudes toward the product, practice, or service	$(\text{Number of audience members with a favorable [or unfavorable] attitude toward the product, practice, or service} / \text{Total number of audience members}) \times 100$
Percentage of non-users of intended audience who intend to adopt FP in the next three months.	$(\text{Among individuals from the intended audience who are currently not using an FP method, the number that report they intend to start using an FP method in the next three months} / \text{Total number of individuals within the intended audience who are not currently using an FP method}) \times 100$
Percentage of intended audience members with favorable attitudes towards FP providers	$(\text{Number of individuals from the intended audience who agree/strongly agree with statements expressing favorable attitudes towards FP providers} / \text{Total number of individuals within the intended audience}) \times 100$
Percentage of intended audience who believe that most people in their community approve of people like them using FP	$(\text{Number of individuals from the intended audience who agree/strongly agree with the statement "Most people in my community approve of people like me using FP"} / \text{Total number of individuals within the intended audience}) \times 100$
Percentage of intended audience who know where to obtain FP in their community	$(\text{Number of individuals of intended audience who can correctly name at least one source of obtaining FP services/supplies in their community} / \text{Total number of individuals within the intended audience}) \times 100$

For more information on measuring social norms, see “Resources for measuring social norms” in the “Additional Resources” section of this document.

Operationalizing the Circle of Care Model[©]

During Stage:

Improve the Client-Provider Interaction



Overview of the Stage

The **During Stage** refers to the point in the continuum when clients are actively accessing services, generally in a facility setting but also at home or through outreach and mobile services. During this stage, SBC initiatives can be used to do the following:

1. **Empower clients:** Support clients to express their needs, concerns and symptoms by increasing their health literacy, confidence, self-efficacy, and knowledge about a health issue or service
2. **Improve provider behavior:** Improve provider skills and influence their attitudes towards clients by addressing underlying assumptions based on cultural norms and personal beliefs that may lead to biases in care, and addressing providers' needs for recognition and support
3. **Build trust:** Positively influence trust between communities and services by influencing providers' interactions with clients and showing providers as credible and caring

What Skills Are Needed at This Stage?

In the “During” stage, SBC implementers need to understand factors that influence provider-client interactions and have the skills to influence client and [provider behavior](#) to improve the likelihood of accurate diagnosis, suitable treatment, and client adherence to treatment. The “Additional Resources” section of this document provides more information on designing and implementing provider behavior change initiatives.

Specifically, implementers should have the skills to do the following:

- Identify factors that influence client and provider behaviors and barriers to quality client-provider interactions
- [Assess and design provider behavior change initiatives](#) using evidence-based strategies
- Facilitate community dialogue and reflection
- Design interpersonal communication and counseling trainings
- Design job aids and other tools to improve quality of care
- Engage in human-centered design

Sample Activities

In the During Stage, SBC practitioners should design initiatives that improve the client-provider interaction by empowering clients, improving provider behavior, and building trust between communities and service providers. This section contains a list of sample activities and six more detailed activity descriptions.

When selecting During Stage activities, implementers should remember to

- Choose activities that meet the audience’s specific needs, values, and barriers
- Consider the evidence base before selecting activities (the [Circle of Care During Stage Brief](#) shares evidence on effective interventions)
- Reach audiences through multiple channels; single channel initiatives are rarely effective
- Choose activities that fit within the project’s budget and timeline



Activities to Empower Clients

Research has shown that clients who express their needs, concerns and symptoms during sessions with health providers are more likely to give information that providers require to reach an accurate diagnosis, offer appropriate advice, and offer suitable treatment.⁶ However, [social and gender norms](#) often do not support engaged and empowered clients—especially female clients—and women and men are often not equipped with the skills they need to communicate effectively about personal and sensitive subjects. SBC can help to empower clients by increasing their health literacy, confidence, self-efficacy, and knowledge about a health issue or service.

Improve Client Knowledge

Health information cards, hotlines, and mobile applications with detailed health information can be used to educate clients so they can ensure they are receiving quality care. For example, health information cards can be used to inform caregivers of young children about fake or sub-standard medicines and empower them to ask providers questions or demand high-quality medicines from a pharmacist.

6. Kim, Y. M., Kols, A., Bonnin, C., Richardson, P., & Roter, D. (2001). Client communication behaviors with health care providers in Indonesia. *Patient Education and Counseling*, 45(1), 59-68.

Tools to Increase Client Self-Efficacy to Communicate with Providers

Client referral cards can include information about a health issue and a list of recommended questions clients can ask their health provider. This tool ensures clients fully understand the provider's recommendation for treatment and follow-up care to monitor a health condition and seek other necessary health services. For example, referral cards for FP services could provide information on different methods and sample questions for providers such as, "How effective is this method?" and, "What side effects should I expect while using this method?"



Activities to Improve Provider Behavior

Many constraints to effective client-provider interactions exist. 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. SBC can be used to improve provider skills and support positive provider attitudes and behaviors, particularly by understanding and viewing providers as an audience for behavior change, rather than a conduit for changing the behaviors of clients. With this mindset, SBC programs can address underlying assumptions and attitudes held by providers that are based on cultural norms and personal beliefs that may negatively influence care (e.g., providers may think that long-acting, reversible contraceptives are not appropriate for young people). Peer modeling and training programs paired with supportive supervision or coaching are two strategies SBC practitioners can employ to change provider behavior.

Additional Sample Activities: Provider-focused activities

- Conducting a provider-specific behavior assessment to determine provider attitudes, biases, behaviors, skills, and working conditions that can impact quality of care
- Hosting values clarification and attitude transformation activities
- Providing communication and empathy training for health facility staff at all levels (e.g., providers, pharmacists, nurses, receptionists, and greeters)
- Creating job aids that prompt providers to provide complete and unbiased counseling and promote a client's informed choice
- Supervising and mentoring providers
- Hosting provider group problem-solving sessions

Peer Modeling

Provider bias can be influenced through peer modeling, or by showing providers examples of others effectively counseling clients or performing a desirable behavior in peer support meetings, on video, or through other media. For example, providers' negative attitudes and beliefs towards young married women who are interested in FP can be influenced by modeling peers who do not allow bias to impact the quality of their counseling. Professional associations or community groups can also influence provider behavior by creating "provider of the year" awards for those who meet a high standard of quality counseling or provision of services in certain health areas.

Counseling Training Paired with Supportive Supervision/Coaching

At the district level, ministries of health can implement and support training programs that guide providers on how to interact and communicate with clients and offer unbiased and accurate information during health visits. Combining training programs with supportive supervision and coaching is more effective at changing provider behavior than training alone.⁷ Job aids could be discreetly placed in health facilities and used to reinforce messages from trainings and provide prompts or step-by-step instructions on how to engage and counsel clients on topics like FP.

Additional Sample Activities: Provider-focused activities

- Posting cues to action at facilities like signs highlighting legal standards of care, rights-based services, and harm reduction principles
- Recruiting and training CHWs to provide FP materials at home visits (e.g., pills, condoms, and injectables)
- Offering non-financial rewards to incentivize provider behavior change

⁷ Rowe, A.K., Rowe, S.Y., Peters, D.H., et al. (2018). Effectiveness of strategies to improve health-care provider practices in low-income and middle-income countries: a systematic review. *Lancet*, 6(11), E1163–E1175. [https://doi.org/10.1016/S2214-109X\(18\)30398-X](https://doi.org/10.1016/S2214-109X(18)30398-X)



Activities to Build Trust

From the person who greets clients at a health facility to the provider delivering treatment, establishing a supportive and friendly environment can build trust and significantly contribute to improved access to services. SBC can positively influence trust between communities and services by influencing providers' beliefs and behaviors that affect their interaction with clients. And in turn, SBC can influence clients' perceptions of providers and other health care staff as credible, compassionate and caring individuals who can be trusted.

Exercises to Increase Empathy and Transparency

Facility staff at all levels (i.e., greeters, pharmacists, and nurses) can participate in exercises to increase empathy with the client experience by creating a journey map that outlines a client's experience at the health facility and identifies how staff can better help clients navigate their care. This can be paired with facility walkthroughs, where the community is invited to meet staff and tour the health facility, and community dialogues to increase trust in providers and the health system. These exercises can help to build facility staff empathy with clients, elevate the perception of quality of care by community members, and build trust in the overall health system.

Community Engagement and Feedback Systems

Trust in providers, facilities, and health systems can be built through community engagement and feedback processes that enable clients to speak out about their needs and interests. Community-based facilitators can lead discussions between community members and providers to share perspectives about the experience of providing and seeking health services. Digital surveys, apps, feedback boxes, and client exit interviews can be used to ensure community voices are heard. Community members can also be involved in identifying and rewarding stellar providers and facilities.

Additional Sample Activities: Provider-focused activities

- Operating education campaigns to improve health literacy
- Role-playing client-provider interactions with potential clients to learn about the questions a provider might ask, how to express their needs, and potential treatment options
- Hosting community theater events that model positive client and provider interactions and provide information about relevant health issues and services
- Designing and implementing client feedback systems to improve services
- Sharing testimonials from satisfied users or hosting "get to know you" campaigns that enable clients to get familiar with their local providers
- Encouraging the use of client-provider commitments or pledges

During Stage Case Studies

Smart Client/Smart Couple: Global/Nigeria and Côte d'Ivoire

In many low- and middle-income contexts, social and gender norms often make it particularly difficult for women to express their FP needs. Women are often passive participants in FP in the home and in the clinic, and these decisions are often made by family members, male partners, or providers.

The digital health tool, [Smart Client/Smart Couple](#), combines entertainment, education, and mobile technology to address this challenge, and aims to increase women's FP knowledge and communication skills to help them become informed, empowered, and confident FP clients. The tool, developed and tested in Nigeria and Côte d'Ivoire and intended for adaptation to any context, is designed for women and men of reproductive age. Smart Client/Smart Couple uses IVR to deliver a short-format drama story, and optional segments including sample dialogues, personal stories, and quizzes.

A Smart Couple user study conducted among 670 women and 652 men of reproductive age in Kaduna City, Nigeria, showed that higher exposure to the mobile intervention increased the odds of discussing FP with one's spouse more than 12-fold for men and 10-fold for women. Higher exposure was also associated with a 12-fold increase for men and a nine-fold increase for women in the odds of discussing contraceptive methods with one's spouse, and a four- and eight-fold increase in discussing the need to visit an FP provider with one's spouse among men and women, respectively. High exposure to the intervention was also associated with increased support for women using FP, likelihood of discussing family size with a spouse, and contraceptive method use intention among both men and women.



Source: Gillespie, B. (n.d.). Courtesy of Photoshare.

Breakthrough RESEARCH: Respectful Maternity Care, Zambia

The USAID-funded Breakthrough RESEARCH project applied [a behavioral design process](#), led by consortium partner ideas42 and implemented in partnership with Safe Motherhood 360+ and the Chipata District Health Office in Zambia, to identify and address behavioral challenges preventing providers from adhering to best practices during facility-based deliveries, specifically around provision of respectful maternity care (RMC).

Focusing on provider behaviors, Breakthrough RESEARCH designed a set of simple, adaptable, low-cost solutions to improve client satisfaction and provider provision of RMC:

1. **BETTER Pain Management Toolkit:** The toolkit included pain management technique posters and manual, massage balls, and partograph guide. BETTER is a mnemonic of pain management techniques (Breathe, Encourage, Turn, Think, and Rub).
2. **Feedback Box:** Women received a token upon discharge from the maternity ward and were instructed to insert the token into the feedback box with the label that best reflected how satisfied they were with their delivery experience.
3. **Provider–Client Promise:** This promise was read aloud and signed by both parties upon admission to the labor ward in order to clarify and set expectations for behavior on both sides.
4. **“Fresh Start” Funds:** Facilities were provided with a small fund to make small changes to the labor ward to improve the client experience.
5. **Reflection Workshop:** A workshop to help providers develop intentions to change care practices and to introduce the other solutions.

Evidence from a quasi-experimental evaluation suggested that clients who were exposed to the solutions were less likely to experience disrespect and abuse and more likely to experience improved provision of pain management. Qualitative findings included that the solutions were easy to implement, providers remarked that the pain management toolkit improved their provision of care, and clients appreciated the promise and said it gave them confidence in the care they would receive.

During Stage Implementation Tips

- **Training alone is less effective** at changing provider behavior than other initiatives, like group problem solving, especially when provider attitudes and beliefs are the main factors influencing their behavior. Training is also more effective when paired with supervision and mentoring than when provided as a standalone activity.⁸
- **Providers and clients should be brought together** to identify mutual needs and benefits to quality service provision; use these opportunities to improve transparency and develop provider empathy for clients.
- **Engage local stakeholders and government representatives.** Implementers and implementation partners should engage with local and government stakeholders to ensure support for the initiative and better position the approach for scale-up. Involving communities and government stakeholders in goal setting and the design process can be an effective way to get buy in and support for the initiative.
- **SBC and service delivery partners should coordinate closely** to ensure that any increases in demand coincide with proportionate increase in high-quality, available services. The “Operational considerations for coordinating SBC and service delivery programs” heading in the “Additional Resources” section lists more information on effective SBC and service delivery partner collaborations.
- **Consider social and structural factors** that play a role in influencing provider behavior and a client’s experience of care. For example, hierarchical systems that govern interactions between health providers and staff, gender norms, and norms around client privacy, among other factors, can all impact a provider’s behavior and client’s experience. To identify the most important factors influencing provider behavior, implementers can conduct a [provider behavior assessment](#) and then design activities to address the most important barriers to quality care. Additionally, implementers should consider whether small structural changes, like improvements to the health facility, can improve client experience and service utilization.

⁸ Rowe, A.K., et al. (2018). Lancet. (See footnote 7).

Sample During Stage Indicators

This section presents a small selection of illustrative indicators that practitioners can use to measure During Stage activities. These and other validated indicators are in the [SBC for Family Planning Service Delivery Indicator Bank](#) and the [Family Planning and Reproductive Health Indicators Database](#).

For additional guidance, please refer to the [Twelve Recommended SBC Indicators for FP brief](#) and accompanying [Indicator Reference Sheets](#), developed by Breakthrough RESEARCH.

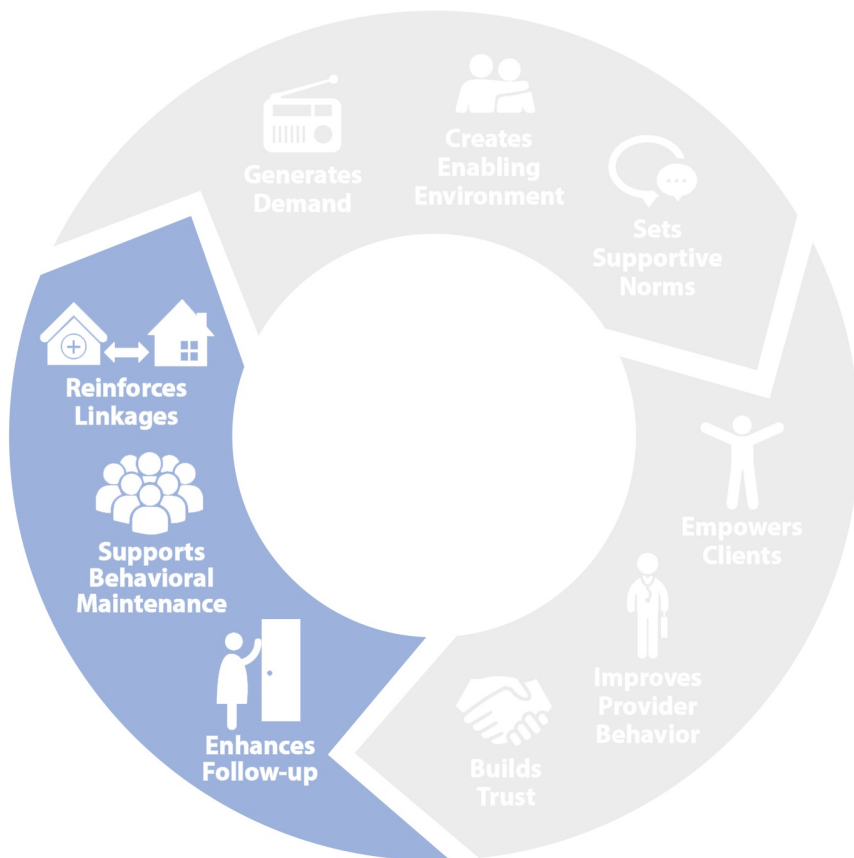
Table 2. Sample During Stage Indicators

Indicator	Calculation
Method information index/informed choice	The reported value is the percent of women who responded “yes” to all three questions.
Percentage of FP service providers reporting the use of FP communication materials in the past three months (or a specified reference period)	$(\text{Number of FP service providers that report having used communication materials on FP in the past three months (or a specified reference period)} / \text{Total number of FP service providers}) \times 100$
Percentage of intended audience who reported that they received FP information from a facility- or community-based health provider in the last 12 months (or a specified reference period)	$(\text{Number of individuals from the intended audience that received FP information from a facility- or community-based health provider in the last 12 months} / \text{Total number of individuals within the intended audience}) \times 100$
Percentage of women of reproductive age that were informed of other FP methods besides their preferred method, among those that visited an FP provider in the past 12 months (or a specified reference period)	$(\text{Among women of reproductive age (15-49 years) that visited an FP provider in the past 12 months, the number that report that their FP provider informed them of other FP methods besides their preferred method} / \text{Total number of women of reproductive age (15-49 years) that visited an FP provider in the past 12 months}) \times 100$
Percentage of women of reproductive age currently using a modern FP method reporting they obtained their contraceptive method of choice	$(\text{Number of women who reported that they obtained their FP method of choice, among women of reproductive age (15-49 years) using a modern FP method} / \text{Number of women of reproductive age (15-49 years) currently using a modern FP method}) \times 100$

Operationalizing the Circle of Care Model[©]

After Stage:

Boost Adherence and Maintenance



Overview of the Stage

In the **After Stage**, clients are often faced with starting a new healthy behavior or remaining motivated to continue a healthy routine, such as treatment, daily medication or change of diet. During this stage, SBC initiatives can be used to

1. **Enhance follow-up:** Create a supportive environment that encourages clients to stay engaged after their initial visit to the clinic.
2. **Support behavioral maintenance:** Address contextual issues, such as interpersonal relationships, that might negatively influence sustained behavior change, including medication adherence.
3. **Reinforce linkages:** Support the development and promotion of referral systems that help to connect clients from their home or communities to health care facilities and from one service to another

What Skills Are Needed at This Stage?

In the **After Stage**, the audience's barriers to maintaining behaviors and identify health system challenges and breakdowns need to be understood (e.g., lack of **After Stage** counseling skills), so implementers can design initiatives that support clients in adopting new behaviors and establish the right linkages between clients and the health system.

Specifically, implementers should have the skills to do the following:

- Identify and address clients' barriers to behavioral maintenance or accessing follow-up care (e.g., difficulty remembering to take a birth control pill every day)
- Locate breakdown points in the health system (e.g., when a client does not seek services after receiving a referral)
- Design and maintain referral systems
- Train on and promote effective **After Stage** counseling, including the ability to respond to client concerns
- Find community groups and resources to support clients

Sample Activities

In the After Stage, public health practitioners should design initiatives that boost adherence and maintenance by enhancing follow-up, supporting behavioral maintenance, and reinforcing linkages between clients and health care facilities. This section contains a list of sample activities and six more detailed activity descriptions.

When selecting After Stage activities, implementers should remember to

- Choose activities that meet the audience’s specific needs, values, and barriers
- Consider the evidence base before selecting activities (see the [Circle of Care After Stage Brief](#) for evidence on effective interventions)
- Reach the audience through multiple channels; single channel initiatives are rarely effective
- Choose activities that fit within the project’s budget and timeline



Activities to Enhance Follow up

Despite the need for continued care, many clients disengage after their initial visit to the clinic. They forget follow-up appointments or might not know or see the importance of adopting or maintaining healthy behaviors, such as taking their medication on a regular basis or managing side effects of an FP method. SBC initiatives can help create a supportive environment by linking clients with peer navigators or utilizing digital follow-up methods so that clients remain engaged along the continuum of care.

Peer Navigator Programs

Peer navigators can be paired with community members who have similar health conditions to serve as role models, mentors, and reliable sources of information to help clients maintain positive health behaviors and stay engaged in treatment. For example, peer navigators who are living with HIV can help newly diagnosed community members accept their diagnosis and provide the support they need to navigate treatment and the health system and adopt new behaviors to manage their condition.

Digital Follow-up

Providers and community health workers or volunteers can use SMS, WhatsApp, and other forms of digital communication to both follow-up with clients about various health issues, disease self-management, and side effect management and remind clients of upcoming appointments to improve adherence and retention in care. For example, automated text or voice messages can be sent to pregnant women about the effects of malaria on their pregnancy and remind them about antenatal care (ANC) appointments; postpartum women can be reminded of available FP methods, where they can access contraceptives and be provided contact information for community health workers or counselors who can provide additional support.



Activities to Support Behavioral Maintenance

Some behavioral changes interfere with daily activities, such as changes in bleeding patterns and other contraceptive side effects, or medications that require multiple doses each day. Families or communities may not maintain their support of behavior change if they find the new behaviors uncomfortable or inconvenient. Stigma, discrimination, and social norms also strongly influence behaviors. Illnesses such as tuberculosis, HIV, and cancer all have social stigma attached to them, so patients may not want to be open about their condition, thus complicating behavior change or behavioral maintenance. SBC programs can help to support behavioral maintenance by addressing contextual issues, such as physical, environmental, or interpersonal relationships that might discourage sustained behavior change.

Additional Sample Activities

- Publishing health and treatment information pamphlets or materials for partners and caretakers of clients; this includes calendars to track treatment schedules and follow-up appointments
- Providing referrals to services for the next stage of care or treatment (e.g., referrals for FP services to support a client's transition from using the lactational amenorrhea method to another FP method)
- Defining and emphasizing a provider's role in after care in continuing education programs
- Setting up e-referral systems with appointment and care reminders
- Ensuring that CHW follow-up with clients at home to discuss side effects, behavioral maintenance, and/or necessary follow-up care

Home Visits

Peer facilitators, community health workers, and/or nurses can provide home visit health talks about the importance of various medications and treatments, managing side effects, and behavioral maintenance. For example, community health workers could visit pregnant women and new parents at home to talk about the importance of regularly sleeping under bed nets to prevent malaria, receiving prompt treatment for malaria, and regular ANC.

Support Groups

Implementers can work with community members to form support groups for persons with similar circumstances or health conditions. Support groups provide regular opportunities for social support and problem solving and can improve retention in care and treatment programs, reduce stigma associated with certain health conditions, and enhance disclosure. For example, support groups for people living with HIV have been shown to improve antiretroviral therapy adherence and retention in care.^{9,10}

Additional Sample Activities

- Establishing the use of client-provider promise cards to reinforce linkages to the health system and each party's responsibilities

9 Rich, M.L., Miller, A.C., Niyigena, P., et al. (2012). Excellent clinical outcomes and high retention in care among adults in a community-based HIV treatment program in rural Rwanda. *Journal of Acquired Immune Deficiency Syndromes*, 59(3), e35-e42. <https://doi.org/10.1097/qai.0b013e31824476c4>

10 Muhamadi, L., Tumwesigye, N.M., Kadobera, D., et al. (2011). A single-blind randomized controlled trial to evaluate the effect of extended counseling on uptake of pre-antiretroviral care in Eastern Uganda. *Trials*, 12(1), 184. <https://doi.org/10.1186/1745-6215-12-184>



Activities to Reinforce Linkages

Referral and linkage systems are key components of high-quality services as they act to increase accessibility. Effective referral systems combine high-quality communication and operations (structure, monitoring systems, and referral tools) and help to connect clients from their home or communities to health care facilities. Doing this well requires collaboration between the SBC partner (often responsible for the “look and feel” of a referral system, particularly if it is branded) and the service delivery partner (responsible for acknowledging and accepting referrals for services). SBC programs can help to reinforce linkages to the health system by prompting patients to seek care via client advocates or passport cards with information on when to seek care in the future.

Client Advocacy

Satisfied clients can be recruited to refer other persons in their network with health issues to community health workers or health facilities for care and treatment. For example, to reinforce linkages between pregnant women and the health system, new mothers can be recruited to help identify malaria symptoms in pregnant women and refer and accompany them to the health clinic for further assessment. In addition, community dialogues with local leaders and health providers can help secure buy-in and support for regular ANC visits and preventive malaria treatment.

Passport Cards

Providers and health workers can distribute cards to clients with health information, referrals, and/or prompts to schedule future health appointments to enhance linkages to follow-up care and treatment. For example, vaccination passport cards could be given to parents after their child receives an immunization that shows what immunizations their child has received, which immunizations they still need, and when they should receive those immunizations. The card helps parents keep track of their child’s immunization history and prompts them to schedule future immunizations according to the recommended schedule.

After Stage Case Studies

Breakthrough ACTION, Côte d'Ivoire

In Côte d'Ivoire, maintaining those who test positive for HIV in treatment has been difficult through traditional outreach channels and targeted initiatives. The [Breakthrough ACTION project](#) seeks to improve retention of HIV treatment amongst HIV-positive males aged 25 years and older, and HIV-positive males and females (aged 15–24) who are identified through Breakthrough ACTION's community testing activities through the use of a peer navigator approach.

Peer navigators are trained to

- Provide patients with information on the benefits of care and treatment services following HIV diagnosis and link them to care
- Provide individualized support in the form of regular follow-up by phone, psychosocial support, referrals to group support, accompaniment to appointments, and home visits to improve uptake and adherence to treatment
- Provide support to the antiretroviral (ARV) community-based distribution team to facilitate access to ARV for people living with HIV and ensure that HIV clients have sufficient stock of their medication, especially during a crisis such as COVID-19
- Deliver and explain the use of self-test kits to men deemed to be at high-risk for HIV and who refuse a traditional HIV test

During fiscal year 2020, to improve adherence and retention, Breakthrough ACTION peer navigators conducted follow-up phone calls and house visits to find 14,334 clients living with HIV who had been lost to follow-up and 8,188 clients living with HIV who had missed their appointments. Among the 22,522 clients living with HIV who were found, 9,660 were linked to services and retained in care. In addition, 1,816 people living with HIV received their three-month stock of ARV from peer navigators at the location of their choosing. Peer navigators also delivered 3,858 self-tests to hard-to-reach men and 2,022 were used (52%).

The project found that, critically, peer navigators must have an intimate understanding of the lived experienced of people living with HIV and familiarity with both community-based and clinical services. Provision of consistent monitoring and supervision of peer navigators has also been important, as peer navigation work is labor-intensive and peer navigators can easily experience burn out or be demotivated, which will impact their performance.



Source: Bernard, K. K. (2020). Peer Navigator handing out ARV's to one of his client. Divo, Côte d'Ivoire.

Maternal and Child Survival Program, Ethiopia

The project sought to address problems in linking a woman's FP choices during antenatal counseling with postpartum contraceptive service delivery. Women can have many contacts with health providers from pregnancy through the extended postpartum period at both the facility and community level; given this, providers have difficulty following women over time, meaning these women may not be effectively counseled on postpartum family planning (PPFP), able to decide about use, and receive their selected method of FP.

The project modified an existing integrated maternal and child health (IMCH) card, which health extension workers (HEWs) complete at all visits with the mother and child, to include PPFP in every section: pregnancy, birth, postnatal care, immunization, and growth monitoring. The project encouraged HEWs to document the PPFP method selected and adopted as appropriate and to refer to the previous sections when they were seeing a female patient. The project provided supportive supervision roughly every other month to explore how HEWs were integrating services, filling out the IMCH card, and recording PPFP information. While choice of PPFP method may evolve over time, recording a choice on a card and using that to revisit the choice in later visits improves HEWs' ability to track and follow-up with clients until they decide whether to choose a PPFP method. Furthermore, the card also allowed for women to say she needed more time before making a choice, prompting more in-depth counseling at a later visit.

The project completed qualitative in-depth interviews with HEWs to solicit feedback on implementing PPFP and the use of the modified tool. HEWs reported clients were pleased when they could recall prior conversations about PPFP and follow up at a subsequent visit. They reported that it changed the counseling relationship and created trust.



Source: Pfitzer, A. (2018). Visiting a health post involved in the PPFP study in Ethiopia. Pictured are the Jhpiego Study Field Supervisor China Wondimu, and Health Extension Worker, Aynalem Tsegaye. Ethiopia.

Mobile Technology for Improved Family Planning, Cambodia

Unmet need for contraception remains a public health issue in Cambodia. The [Mobile Technology for Improved Family Planning \(MOTIF\) study](#) aimed to reduce unmet need through a mobile-based initiative to offer contraception as part of post-abortion care at four Marie Stopes International clinics. Research had shown that women in Cambodia had difficulty in making decisions about contraception when seeking services. Given that over 90% of women surveyed own a cell phone, and 80% of the population lives in a rural area where access to services is limited, a mobile phone-based intervention could provide an effective method for maintaining communication with clients after they leave the clinic.

The study randomly allocated 249 women to a mobile phone-based intervention, which comprised six automated, interactive voice messages with counsellor phone support depending on their responses to messages, and additional reminder messages as appropriate. 251 women were allocated to a control group receiving standard care. The primary outcome was the self-reported use of an effective contraceptive method.¹¹

Data on effective contraceptive use were available for 431 (86%) participants at four months and 328 (66%) at 12 months. Significantly more women in the intervention than the control group reported effective contraception use at four months (64% versus 46%, respectively; relative risk (RR): 1.39; 95% confidence interval (CI): 1.17–1.66) but not at 12 months (50% versus 43%, respectively; RR: 1.16; 95% CI: 0.92–1.47). However, significantly more women in the intervention group reported using a long-acting contraceptive method at both follow-up times. No significant difference existed between the groups in repeat pregnancies or abortions at four or 12 months. Adding a phone-based intervention after services has the potential for increasing use of contraceptives.¹²



Source: Uk, V. (2013). MOTIF phone counsellors. Phnom Penh, Cambodia.

11 Smith, C., Ngo, T.D., Gold, J., et al. (2015). Effect of a mobile phone-based intervention on post-abortion contraception: a randomized controlled trial in Cambodia. *Bulletin of the World Health Organization*, 93(12). <https://doi.org/10.2471/BLT.15.160267>

12 Smith, C. et al. (2015). Effect of a mobile phone-based intervention. (See footnote 11).

After Stage Implementation Tips

- **After Care leads to Before Care:** Implementers can enhance the impact of their program by considering a client’s journey through the Circle of Care from After Care to Before Care. For example, postpartum clients may need to transition from After Care activities around recovering from birth to Before Care activities like learning about contraceptive methods they can use for spacing or limiting.
- **Involve all stakeholders:** Clients benefit from social support when attempting to adopt new behaviors and treatment regimens. Community-based initiatives in the After Stage can support clients to accept their diagnosis and continue to seek care. By involving all stakeholders in the After Stage, implementers can create opportunities for families and communities to better support clients after they receive care.
- **Identify and promote small doable actions:** Small doable actions are behaviors that will lead to better individual and community health outcomes and are considered feasible by the persons who will perform the behavior.¹³ While small doable actions “may not be an ‘ideal practice,’” explains a WASHplus Learning Brief, “more households likely will adopt it because it is considered feasible within the local context.”¹⁴
- **Leverage existing health contacts and tools where possible:** Rather than introducing entirely new tools and approaches, first determine whether achieving desired results is possible by leveraging existing tools and resources. For example, the Maternal and Child Survival Program in Ethiopia modified existing IMCH cards to include PFP prompts and developed an orientation package for HEWs with basic PFP concepts and study summary results about the impact of HEW counseling on PFP use. Leveraging existing tools and resources can increase the likelihood that new initiatives will be accepted and adopted by key audiences.

13 USAID. (2015). WASHplus learning brief: Small doable actions: a feasible approach to behavior change. FHI360. <https://www.fhi360.org/resource/small-doable-actions-feasible-approach-behavior-change-learning-brief>

14 USAID. (2015). WASHplus learning brief (see footnote 13).

Sample After Stage Indicators

This section presents a small selection of illustrative indicators that practitioners can use to measure After Stage activities. You can find these and other validated indicators in the [SBC for Family Planning Service Delivery Indicator Bank](#) and the [Family Planning and Reproductive Health Indicators Database](#).

For additional guidance, please refer to the [Twelve Recommended SBC Indicators for FP brief](#) and accompanying [Indicator Reference Sheets](#), developed by Breakthrough RESEARCH.

Table 3. Sample After Stage Indicators

Indicator	Calculation
Percent of clients referred to other FP services	$(\text{Number of FP clients who received a referral for an FP service during the reference period} / \text{Total number of FP clients served at the service delivery point during the reference period}) \times 100$
First year contraceptive discontinuation rates	$(\text{Number of episodes where a specific FP method is discontinued within 12 months after beginning its use} / \text{Number of episodes of FP use among women of reproductive age who began an episode of contraceptive use 3–62 months before being interviewed}) \times 100$
Percent of audience who practice the recommended behavior	$(\text{Number of audience members who report practicing the recommended behavior} / \text{Total number surveyed in intended audience}) \times 100$
Percentage of women of reproductive age who would refer others to their FP provider, among those who have visited a FP provider in the last 12 months	$(\text{Number of women of reproductive age [15–49 years] who would refer a relative or a friend to their FP provider, among those who visited a FP provider in the last 12 months} / \text{Total number of women of reproductive age [15–49 years] who visited a FP provider in the last 12 months}) \times 100$
Percent of audience with favorable self-efficacy for adopting recommended behavior.	$(\text{Number of audience members who report favorable self-efficacy for adopting recommended behavior} / \text{Total number of audience members}) \times 100$

Additional Resources



The Circle of Care Model[©]

The Circle of Care Model[©]:

<http://healthcommcapacity.org/wp-content/uploads/2017/06/Circle-of-Care-Model.pdf>

Before Stage Evidence Brief:

https://behaviorchangeimpact.org/wp-content/uploads/2020/03/FP_COC_BEFORE.pdf

During Stage Evidence Brief:

<https://breakthroughactionandresearch.org/wp-content/uploads/2020/07/Circle-of-Care-During.pdf>

After Stage Evidence Brief:

<http://breakthroughactionandresearch.org/wp-content/uploads/2020/07/Circle-of-Care-After.pdf>

Social and Behavior Change Theory and Determinants

Understanding the Determinants of Behavior Change:

<https://sbccimplementationkits.org/service-communication/lessons/understanding-the-determinants-of-behavior-change/>

Social norms:

<http://irh.org/resource-library/social-norms-background-reader/>

The Role of Behavioral Science Theory in Development and Implementation of Public Health

Initiatives: <https://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.012809.103604>

Program Design

How to conduct a situation analysis:

<https://www.thecompassforsbc.org/how-to-guides/how-conduct-situation-analysis>

Identifying relevant social and gender norms:

<https://sbccimplementationkits.org/service-communication/what-are-the-relevant-social-and-gender-norms/>

How to conduct an audience analysis:

<https://www.thecompassforsbc.org/how-to-guides/how-do-audience-analysis>

How to conduct a provider behavior assessment:

<https://www.thecompassforsbc.org/how-to-guides/provider-behavior-assessment-social-and-behavior-change>

How to segment your audience(s):

<https://www.thecompassforsbc.org/how-to-guides/how-do-audience-segmentation>

Provider Behavior Ecosystem:

<https://www.baproviderbehaviorecosystem.org/>

Asset-based approaches to community development:

<http://csl.ubc.ca/files/2010/04/What-Are-Asset-Based-Approaches-to-Community-Development.pdf>

Gender-synchronized approaches:

<https://www.igwg.org/2018/09/involving-everyone-in-gender-equality-by-synchronizing-gender-strategies/>

How to develop a channel mix plan:

<https://www.thecompassforsbc.org/how-to-guides/how-develop-channel-mix-plan>

How to design SBCC messages:

<https://www.thecompassforsbc.org/how-to-guides/how-design-sbcc-messages>

Program Implementation

Service communication implementation kit, integrating SBCC into service delivery programs:

<https://sbccimplementationkits.org/service-communication/>

Provider behavior change implementation kit:

<https://sbccimplementationkits.org/provider-behavior-change/>

Holding community dialogues:

<http://irh.org/resource-library/mff-community-dialogues-manual/>

Conducting a stakeholder workshop:

<https://www.thecompassforsbc.org/how-to-guides/how-conduct-stakeholder-workshop>

Small doable actions:

<https://www.fhi360.org/resource/small-doable-actions-feasible-approach-behavior-change-learning-brief>

Operational considerations for coordinating SBC and service delivery programs:

<https://sbccimplementationkits.org/service-communication/service-communication-implementation-kit/operational-considerations/>

Monitoring, Measurement, and Evaluation

Twelve Recommended SBC Indicators for Family Planning

- Brief: https://breakthroughactionandresearch.org/wp-content/uploads/2020/11/BR_SBCInd_Brief.pdf
- Indicator Reference Sheets: https://breakthroughactionandresearch.org/wp-content/uploads/2020/11/BR_SBCInd_Ref_Brief.pdf

SBC for Family Planning and Service Delivery Indicator Bank:

<https://breakthroughactionandresearch.org/resources/social-and-behavior-change-indicator-bank-for-family-planning-and-service-delivery/>

MEASURE Evaluation's Family Planning and Reproductive Health Database:

https://www.measureevaluation.org/prh/rh_indicators/indicator-summary

Resources for measuring social norms:

https://www.alignplatform.org/sites/default/files/2019-10/resources_for_measuring_social_norms_guide_final.pdf

The Business Case for Investing in Social and Behavior Change for Family Planning:

https://breakthroughactionandresearch.org/wp-content/uploads/2020/01/20191211_BR_FP_SBC_Gdlns_Final.pdf

Case Study Examples

Before Stage

Fistula Care *Plus*, Nigeria and Uganda:

<https://fistulacare.org/resources/program-reports/barriers-partnership/>

Promoting Change in Reproductive Behavior of Adolescents, India:

<https://www.pathfinder.org/projects/prachar/>

HIV Response: Coordination, Community, Capacity and Communication, Eswatini:

<https://ccp.jhu.edu/2019/08/12/eswatini-community-leaders-data-decisions/>

During Stage

Smart Client/Smart Couple, Global/Nigeria and Côte d'Ivoire:

<https://healthcommcapacity.org/technical-areas/family-planning/smart-client-smart-couples/>

Breakthrough RESEARCH: Respectful Maternity Care, Zambia:

<https://breakthroughactionandresearch.org/applying-behavioral-economics-to-improve-womens-experience-with-maternal-care-in-zambia/>

After Stage

Breakthrough ACTION, Côte d'Ivoire:

<https://breakthroughactionandresearch.org/about/breakthrough-action/>

Maternal and Child Survival Program, Ethiopia:

- <https://www.mcsprogram.org/our-work/reproductive-health/postpartum-family-planning/>
- <https://www.joghr.org/article/13511-effect-of-integrating-postpartum-family-planning-into-the-health-extension-program-in-ethiopia-on-postpartum-adoption-of-modern-contraception>

Mobile Technology for Improved Family Planning Study, Cambodia:

<https://www.who.int/bulletin/volumes/93/12/15-160267/en/>