Applying Social and Behavior Change Approaches to Improve Sexual and Reproductive Health Service Delivery

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Acronyms

FP	Family planning
HCD	Human-centered design
ITN	Insecticide-treated net
PPFP	Postpartum family planning
SRH	Sexual and reproductive health
SBC	Social and behavior change

Purpose and Process

The purpose of this technical brief is to share evidence from Breakthrough ACTION's social and behavior change (SBC) for sexual and reproductive health (SRH) service delivery activities. Based on this evidence, the brief offers lessons learned and recommendations related to SBC for SRH service delivery programming in the public sector.

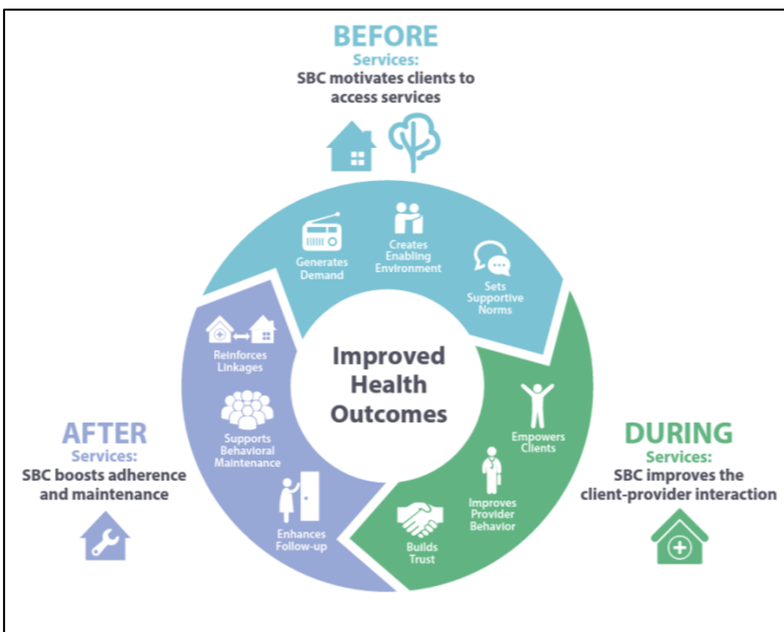
To prepare this brief, the authors reviewed and analyzed available project documentation, monitoring and evaluation data, and reporting from Breakthrough ACTION SBC for SRH service delivery activities. Key information from these materials was captured in a matrix to identify lessons learned and recommendations.

Key Terms

SBC approaches utilize learnings from disciplines like community engagement, behavioral science, human-centered design (HCD), marketing science, and SBC communication to influence attitudes and beliefs, promote positive social norms, and create an enabling environment to promote the adoption of healthier behaviors.

SBC for service delivery refers to using SBC approaches and techniques to improve health service delivery outcomes. SBC for service delivery activities are distinguished by their focus on service interactions, the social and cultural norms that impact service use, and the physical environment in which services are delivered.[1] The Circle of Care Model© (see Figure 1) illustrates how SBC can be applied across the service continuum to motivate clients to access health services (before services), improve the provider-client interaction (during services), and boost adherence and maintenance (after services).[1]

Figure 1: The Circle of Care Model©



From: *From Vision to Action: Guidance for Implementing the Circle of Care Model* by Breakthrough ACTION, 2021, Johns Hopkins Center for Communication Programs.

Lessons Learned and Recommendations

User-centered strategies can effectively uncover and address the unique needs of potential clients, current clients, and providers.

Breakthrough ACTION activities in ***Zambia***, ***Malawi,*** and ***the Democratic Republic of the Congo*** contribute to the growing evidence that user-centered approaches can address the unique needs of clients and providers to improve the client-provider interaction, enable voluntary and informed choice, and increase SRH service uptake.

In ***Zambia***, Breakthrough ACTION used human-centered and behavioral design to identify key behavioral insights related to men's and adolescents' uptake of SRH, HIV, and other health services (see Table 1). Based on these insights, Breakthrough ACTION developed "Wellness Days" to improve the client-provider interaction and increase uptake of SRH, HIV, and other health services among men and adolescents.[2]

TABLE 1: Behavioral insights from Breakthrough ACTION Zambia Formative Research and Literature Review	
MEN	ADOLESCENTS
• Men do not access condoms or HIV testing at health facilities due to concerns about privacy and confidentiality. • Men do not discuss condom use with their partners due to fears that these conversations could imply infidelity. • Men choose not to use condoms in the moment because of a reduction in pleasure. • Men prioritize their children's or families' use of an insecticide-treated net (ITN) over their own because they believe they are at a lower risk of malaria. Men value the health of their families but view their role as providing financial security rather than involvement in health care decisions.	• Adolescents do not seek family planning (FP) or condoms from health centers due to concerns about privacy and confidentiality. • Adolescent girls do not use FP because social norms dictate that it is unacceptable for unmarried females to use FP. • Adolescent girls do not use modern contraceptives other than condoms due to fear of side effects. • Adolescent girls have misconceptions about FP; they believe many methods can cause infertility. • Adolescents do not use ITNs because they or their family members perceive adolescents to be at lower risk of malaria. • Adolescent girls have unprotected sex in transactional relationships (for money, food, or gifts) because they are unable to negotiate condom use in such relationships.

From: *Documenting lessons learned from an integrated social and behavior change program linked to integrated health services in Zambia* by Breakthrough RESEARCH. 2020.

Men aged 20-55 and adolescents aged 15–19 were invited to attend Wellness Days to receive integrated preventive health services (HIV testing and condom provision as well as information about insecticide-treated net use, contraceptive methods, and nutrition). Breakthrough ACTION conducted Wellness Days once per month in selected public health centers.[2]

The project designed Wellness Days around three core components to address the different needs of men and adolescent girls:

1. Adolescents participate in informative group games and activities; Men sign up for appointment slots at the headman's house or outside the health facility
2. Providers use a toolkit to systematically discuss various health topics during individual check-ups. Counseling addressed client knowledge, perceptions, practices, and gender and other social norms that were found to affect the client-provider interaction and service uptake.
3. Adolescents and men receive a take-home packet that included condoms and an advice sheet with key health messages and information about SRH and contraception, malaria, nutrition, and other health issues.

Surveys carried out by Breakthrough ACTION found that clients and providers reported high acceptability of Wellness Days and believed the behavioral insight research resulted in activities that better met the needs of adult men and adolescents. Providers reported the SBC messaging incorporated into Wellness Day counseling and materials led to increased care seeking among both men and adolescents, including for other services offered outside Wellness Days, by creating an enabling environment and reducing stigma. Participation in Wellness Days or exposure to Wellness Days and media programs was strongly associated with support for male and female adolescents' access to contraceptives, including condoms.[2] These initial findings demonstrate how user-centered SBC approaches like human-centered and behavioral design can uncover and address the needs of different audiences, improve the client-provider interaction, and increase the uptake of SRH services.

In ***Malawi***, Breakthrough ACTION used behavioral design to enable informed choice and client satisfaction by addressing the holistic set of behavioral barriers that result in incomplete postpartum family planning (PPFP) counseling.

During formative research, the project found providers in public health facilities were not counseling postpartum clients on the full range of contraceptive methods available for postpartum women in a way they understood and internalized, thereby inhibiting meaningful choice. Although the counseling sessions were interactive, providers did not share information about all methods, focusing on side effects or duration of use. Some providers discussed methods that women said they knew already. Additionally, if a method was out of stock, providers administered other methods, such as Depo-Provera, without discussing with clients whether they could switch to their desired method in the future. Based on observations of counseling sessions and interviews with providers and clients, the project hypothesized incomplete contraceptive counseling was the result of several behavioral barriers: Providers use faulty heuristics.[i]

1. Counseling protocols did not prompt discussion or information sharing about all methods.
2. Providers make incorrect assumptions about their clients' needs and preferences.
3. Providers have an incomplete mental model of client satisfaction (i.e., that lack of questions or complaints always means being fully satisfied with a method).
4. Providers perceive that method switching had high costs and risks so they focus counseling on short-term methods that have a shorter duration and are more reliably available.
5. Providers are not able to consistently follow up with clients who had been given referrals.
6. Providers deprioritize FP counseling in the immediate postpartum period.[3]

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[i] Heuristics are mental short cuts that humans use to make quick judgements and decisions based on incomplete information. Heuristics reduce the cognitive load associated with making decisions but are also vulnerable to biases that can lead to incorrect judgments or solutions.[4]

The project designed five solutions to address the key behavioral barriers uncovered during formative research:

1. **Antenatal care inserts** affixed to a client's ANC "passport" during the third and fourth visit prompted providers to discuss all available PPFP methods, so clients were informed about their options before their baby was born.
2. **Group counseling posters** that providers used during health talks to provide unbiased information to potential clients on all contraceptive methods.
3. **Method referral cards** that providers could give clients to prompt discussion about method satisfaction and the full range of alternatives.[ii]
4. **A referral tracking system** to help providers track if a client followed through on a referral and more easily see the effects of their counseling efforts.[iii]
5. **A values clarification workshop** to reset common myths and misperceptions held by service providers about PPFP, the importance of allowing method switching, and LARC use and refresh provider knowledge about the full range of contraceptive methods, introduce the solutions for feedback, and otherwise create a space to discuss contraception counseling.[3]

A feasibility study found the solutions were easy for providers to implement and integrate into existing processes; providers also reported the solutions had the potential to positively impact client outcomes.[5]

A pre-post study found that, after the intervention period, the percentage of community health workers in the community who reported giving referrals to women of reproductive age for FP uptake at public health facilities increased by 34% ($p<0.01$) and community health workers' knowledge about the timeline for provision/use of PPFP methods increased by 65% ($p<0.05$). The percentage of providers who discussed method switching with all clients increased by 63% ($p<0.05$) and provider attitudes towards same-day method switching increased by 36.4% ($p<0.01$). Health Surveillance Assistants' knowledge of immediate PPFP increased by 34.1% ($p<0.01$).[6]

Findings from both studies show user-centered design approaches can result in desirable, feasible, and effective tools and strategies to improve the provider-client interaction in support of informed choice.

[ii] The referral cards were originally designed for providers in health facilities, who provide postpartum women with SRH services, post-natal care, or under-five consults, to distribute after group family planning counselling when a method was not available or a woman was not sure which method, if any, she wanted to take up that day. However, due to the COVID-19 pandemic, they were adapted for use by community health workers to refer women from the community to a health facility as needed. Community health workers can only provide condoms, injectables or oral contraception pills, so referral cards were given to a woman if she requested a long-acting method, if the CHW ran out of a method, if a woman thought she might be pregnant and needed a pregnancy test, or if the woman wanted more time to think about her options and/or to discuss with her husband.

[iii] The referral system was a box to collect all community health worker-provided method referral cards brought to family planning, post-natal, or under-five consultations. At each clinic, one person was responsible for counting and sharing the number method referral cards collected.

In the ***Democratic Republic of the Congo,*** the VIVA! campaign promoted essential health practices and facility-based care seeking for pregnant women and parents of children under five through a package of interventions co-created with community members and insights generated during the HCD process (see Appendix). The campaign applied Cass Sunstein's FEAST Framework to attract community members to participate in these health activities. The activities were Fun, Easy, Attractive, Social, and Timely. Campaign activities were led by community health workers and other public sector health agents.[7]

People exposed to the VIVA! campaign were more likely to report seeking care at health facilities and participating in campaign activities was linked to increased service use. Of the 15,600 reminder tickets distributed at VIVA! events (couples parties, listening clubs, and market quizzes), 11% were presented at health centers for services. The reminder tickets carried no monetary value towards the cost of services. The tickets were produced in three colors to represent each of the activities where the tickets were distributed. They show seven different services, and the providers checked the services that the person was seeking. The services are fever, ANC, cough, childbirth, diarrhea, well-baby visits/exocrine pancreatic insufficiency, and contraception. Most tickets were redeemed by women (69%). Just under a third of tickets were redeemed by women for prenatal care services (29%); 9% were redeemed for childbirth and 6% for FP services. These results show that SBC strategies can complement and enhance service delivery efforts by increasing uptake of health services.[7]

Recommendation: Utilize user-centered approaches like human-centered and behavioral design to identify and address the unique needs of clients and providers to improve the client-provider interaction and increase uptake of SRH health services.

Empathy building exercises can reduce bias and stigma

Breakthrough ACTION activities in ***Liberia*** found empathy building tools can improve the interaction between young clients and providers by reducing stigma and provider bias.

In ***Liberia,*** Breakthrough ACTION worked with the Ministry of Health to incorporate the Empathways tool into the National Interpersonal Communication and Counseling Curriculum. Empathways is a card activity designed to increase empathy and trust between providers and young people and improve the client-provider interaction and quality of care.

Breakthrough ACTION provided technical assistance for two-day interpersonal communication and counseling trainings held in ten counties in Liberia. Each training had at least 25 public-sector providers—including officers in charge, nurses, midwives, physician assistants, and county health officers—and three youth participants. During the second day of training, three youth participants were paired one-on-one with providers to go through the Empathways cards while the remaining providers observed. Afterwards, all participants discussed and processed their experience together.

Monitoring reports showed improvements in provider attitudes towards young clients after the training. In monthly and quarterly follow-up visits, clients and providers reported increases in provider empathy and improvements in providers' counseling skills and client-centered communication, particularly with

young people. Providers also reported the Empathways activity improved their interactions with young people and increased their openness to discussing contraception with young clients.[8]

These findings indicate that developing empathy and trust between providers and clients can improve service delivery by reducing bias in the client-provider interaction, particularly between providers and youth.

Recommendation: Integrate empathy-building tools and exercises into provider trainings to reduce bias and stigma and build trust between clients and providers; consider supportive supervision and other means of reinforcing progress to promote positive norms.

Engaging communities has the potential to create an enabling environment for SRH care seeking.

Breakthrough ACTION activities in ***West Africa*** found that engaging communities through events and discussions can be a first step towards reducing stigma and harmful social norms that prevent young people from accessing SRH care and services.

In ***West Africa***, Breakthrough ACTION implemented *Merci Mon Héros* ("Thank You, My Heroes"), a multi-media campaign, to increase intergenerational communication about SRH and contraception and create an enabling environment for young people to access SRH and contraceptive information and services. The campaign, co-created and implemented with a team of youth consultants across, at times, seven francophone African countries, disseminated videos of young people sharing experiences of a "hero" in their lives who overcame stigma to support their reproductive health needs. The campaign aims to overcome the impact of restrictive social and gender norms that restrict youth access to SRH and contraceptive information and services by normalizing young people talking about their SRH needs without shame, and by increasing adult empathy for youth's SRH experiences and increasing their support for youth SRH access and informed, voluntary use. The videos were shown at community events and during discussions that also leverage a community-adapted version of the Empathways cards with parents, youth, and community and religious leaders about overcoming social and gender norms to improve young people's access to SRH information and services; they were also circulated via social media, television, and radio. Light-touch monitoring data (n=61; results brief forthcoming) from the campaign's community activities in Togo and Côte d'Ivoire show that, after participating in a *Merci Mon Héros* Empathways discussion, 80% of women and 100% of men said it was acceptable for young person to use contraception. Further, 100% of women and 97% of men said they intended to help a young person access FP methods, and 100% of surveyed men and women from both countries said they intended to talk to a young person about FP. Breakthrough ACTION *Merci Mon Héros* exposure studies (formal write-ups forthcoming) from Côte d'Ivoire and Niger also showed that those exposed to the campaign through any of its multi-media channels were more likely to have recently used SRH services and methods, and to have spoken to someone else about SRH than those not exposed to the campaign.

A qualitative study in Niger and Côte d'Ivoire used the Most Significant Change methodology[iv] to explore the effects of the *Merci Mon Héros* campaign on intergenerational communication and youth access and use of SRH services. Authors found evidence of adults changing their attitudes towards young people using SRH services due to *Merci Mon Héros* activities. Results also showed the campaign increased knowledge and reduced misconceptions about contraceptive methods, leading to more communication within communities on the benefits of SRH services and going to health centers. Young people reported increased self-efficacy in seeking SRH services. Adults and youth reported increased uptake of FP to space or avoid pregnancy and reduce susceptibility to sexually transmitted infection. Survey respondents recommended greater engagement with religious and community leaders to increase the campaign's effectiveness.[9]

These results indicate that engaging communities through media campaigns, storytelling, events, and discussions can contribute to creating an enabling environment for young people to access SRH services. Though *Merci Mon Héros* saw changes in community attitudes towards young people using and accessing SRH services, an important first step towards changing social norms, evaluators noted that sustained, long-term programming would be needed to see meaningful normative change.

Recommendation: SBC for service delivery activities should engage communities to create an enabling environment for SRH service-seeking.

Increasing audience exposure to health service promotion messages can improve service uptake

Breakthrough ACTION in ***West Africa*** suggest that increasing audience exposure to campaign messages and employing a multichannel approach can increase SRH service seeking.

In ***West Africa***, Breakthrough ACTION designed and implemented *Confiance Totale* ("Complete Trust"), a quality branding campaign to increase uptake of SRH services across four countries (Burkina Faso, Côte d'Ivoire, Niger, and Togo). The branding campaign had the dual objective of increasing clients' trust in health care providers and motivating providers to improve service provision quality by conducting self-assessments and adhering to quality standards. Due to COVID-19, the campaign pivoted to focus on what couples could do to prevent unplanned pregnancies and the brand was redirected to promote the safety of FP methods and increase trust in facility-based providers to serve the interests of clients. With the coup d'état in Burkina Faso, the project interrupted work with the public sector to focus on private and IPPF affiliated services using the same brand. In Togo, the campaign was used to promote specific services that had been evaluated and that demonstrate quality FP services. In Burkina, the brand is being used as a generic FP demand creation campaign, and in Côte d'Ivoire, it is being adapted slightly to promote free FP services in a set of test districts.

[iv]The Most Significant Change methodology is based on analyzing a collection of stories about the intervention being evaluated."[9]

The campaign promoted partner communication about FP and trust in providers through short radio clips, based on the premise that promoting safe and effective contraception within an enabling environment that supports women/couples voluntary and informed choices would increase the uptake of FP services. Results from mobile phone-based monitoring surveys in Côte d'Ivoire found statistically significant relationships between recall of exposure to the campaign and three outcomes:

1. ***Intent to seek FP information or services:*** Respondents who heard campaign messages at least once per day were over three times more likely to report their intent to seek FP information or services at a health facility in the next 6 months compared to those who did not recall hearing the radio spots at all (OR= 3.4 for males and 3.1 for females; $p<.001$). Respondents who recalled hearing the campaign messages at least once a week were 1.2 (males) and 3.1 (females) times more likely to report their intent to seek FP information or services at a health facility in the next 6 months ($p<.01$) than people who did not recall hearing the messages.
2. ***Communication about FP with a provider:*** People who recalled hearing campaign messages at least once a day were 2.9 (males) and 2.5 (females) times more likely to have talked to a health provider about FP in the previous month ($p<0.001$) compared to respondents who did not recall exposure to the campaign. People who recalled hearing campaign messages at least once a week were 1.9 (males; $p<.05$) and 1.6 (females; $p>.05$) times more likely to have talked to a health provider about FP in the previous month.
3. ***Current FP use:*** Respondents who recalled hearing campaign spots at least once per day were 2 (males; $p<.05$) and 2.9 (females; $p<.01$) times more likely to report current FP use) than people who did not recall hearing the messages. For each additional week of data collection, respondents who recalled hearing campaign spots were 10% (males) and 9% (females) more likely to report current FP use compared to the previous week ($p<.05$).[10]

The results suggest a dose-response relationship between exposure to campaign messages and intended outcomes. However, evaluators noted the radio audience skews male and recommended future programs consider multichannel approaches to reach women as well as men.

In ***Guinea***, the integrated *Parents Fiers* ("Proud Parents") SBC campaign employed a multi-channel approach to promote FP for birth spacing, couple communication about family health, importance of paternal engagement in family health matters, routine childhood immunization, and safety precautions related to COVID-19 when visiting health centers. The campaign messages were shared via radio spots and shows, billboards, interactive voice response messaging, community engagement, and social media. Those who recalled having seen or heard the campaign messages in the last three months had a higher intention to use FP to space births compared to those who had not been exposed to campaign messages (73.3% vs. 64.7%; $p<0.001$), and those who were exposed to campaign messages through three or four channels had more than two times higher odds of reporting intention to use FP compared to those who were not exposed (OR: 2.18 and 2.08; $p<0.001$).[11] This evidence supports the notion that multi-channel approaches are particularly beneficial for generating demand for SRH services.

Recommendation: Consider a multichannel communications approach and increasing message frequency to increase SRH service uptake.

SBC for SRH service delivery programming can complement systems-focused approaches.

Results from Breakthrough ACTION in ***Zambia*** show that SBC activities designed to create an enabling environment for care seeking can positively impact other, unintended health behaviors, highlighting the potential of SBC for SD activities to complement health systems strengthening activities.

In ***Zambia***, providers observed that male and youth clients who attended Wellness Days were returning to health clinics to access other health services such as dental care, male circumcision, and cancer screenings. Providers attributed this increase in demand to SBC messaging during Wellness Days that encouraged and created an enabling environment for care seeking by reducing stigma and bias (i.e., stigma associated with men seeking care and men believing that health services aren't "for them," and young people face bias from providers who think they are too young to access SRH services and contraception). The project noted this may be more likely to occur when an increase in "'gateway behaviors" such as HIV counseling and testing influences demand for services like male circumcision."[2] Program evaluators recommend SBC for SRH service delivery projects consider how activities may affect demand for additional health services and strengthen referral mechanisms for clients to ensure comprehensive care.[2]

Recommendation: Design SBC, service delivery, and SBC for service delivery activities with a systems lens to ensure clients can access services and receive comprehensive care; seek opportunities to design SBC for service delivery activities in concert with health systems strengthening approaches.

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Appendix

Insights	Activity	Intermediate Indicator/Changes	Outcomes
Caretakers are not capable of recognizing when symptoms become severe enough to seek treatment at a health facility. Knowledge about health is limited to 'sensitization' provided from the RECOs. Households that have been reached or have contact with RECOs have more knowledge of healthy behaviors. Lack of experience and ignorance provide a fragile environment for young women who are recently married, and who become pregnant. Their education about pregnancy and childbirth comes from in-laws, who may not know much more, and whose desires for grandchildren may put women at risk.	Market Quiz, Couples Parties, 42502 Healthline, RECO Home Visits	Knowledge and attitudes about symptom severity Knowledge of the services offered at HC Belief in benefits of EHHP	Increased practice of key accelerator behaviors including care seeking at health facilities for children under age 5
Healthcare expenses are secondary or tertiary behind expenses for food and education. A delay in treatment seeking, increased costs as multiple solutions are tried and higher pressure for health facilities to treat very sick children and adults. Price uncertainty is a source of worry and anxiety, and ultimately a barrier to formal health service use. In many cases, people approach health facilities without knowing the exact price of the services that will be provided to them. This creates a feeling of unease and a preference towards sticking to what is known to them, or the option of paying in kind. The lack of financial means causes couples to minimize the risk of not being treated well and not delivering their babies in a health center. Families are making health care decisions based on cost, access, cultural considerations, and proximity, rather then on quality of health outcomes.	Cost Comparison, Savings Banks	Perception that health services are affordable Perceived barrier of health service costs	Increased care-seeking at health centers Increased satisfaction with health center
Women's work is not considered work since these tasks do not represent any economic benefit for the household. However due to the multiple tasks and responsibilities women must complete each day, childcare for the infants is filled with risk. Responsibility for childcare is not shared with the husband of the household. The husband is the principal decision-maker for seeking treatment or care. He is not well equipped to decide between therapies - traditional, religious or modern, and acts as a barrier to any care. The lack of couple's conversation and interactions are a threat to empathy and understanding between them.	Couples Parties	Couple communication about EHHP and care seeking Self-efficacy & Intention to use services, including ANC and delivery Participation of men in health decision-making	Increased practice of key accelerator behaviors including FP, ANC4
People would accept to pay for health services if the services are not disappointing. Information about a bad experience with health providers/ health facilities spreads fast. Trust between the community and the health system is often missing. Although all religious leaders and traditional healers are not trained in health, people trust and rely on them for guidance in care. Even though they could be bridge for safe healthcare, they are, in most cases, an obstacle. If the religious leader decides to treat an illness, the person will no longer go to a health facility.	Quality Health Centers	Perceptions of health center quality Favorable attitudes about using health facilities	Increased satisfaction with health center

From: *VIVA! campaign: An important step in improving Congolese lives.* Breakthrough ACTION. 2022. Unpublished.