A Guide for Planning and Implementing Social and Behavior Change Communication Activities for Postpartum Family Planning
The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health’s flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

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## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>BA</td>
<td>Barrier Analysis</td>
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<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>DBC</td>
<td>Designing for Behavior Change</td>
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<tr>
<td>EBF</td>
<td>Exclusive Breastfeeding</td>
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<tr>
<td>EC</td>
<td>Emergency Contraception</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>HTSP</td>
<td>Healthy Timing and Spacing of Pregnancy</td>
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<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
</tr>
<tr>
<td>LAM</td>
<td>Lactational Amenorrhea Method</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MCHIP</td>
<td>Maternal and Child Health Integrated Program</td>
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<tr>
<td>MNCH</td>
<td>Maternal, Newborn, and Child Health</td>
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<tr>
<td>MNH</td>
<td>Maternal and Newborn Health</td>
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<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>PLA</td>
<td>Participatory Learning and Action</td>
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<tr>
<td>PPFP</td>
<td>Postpartum Family Planning</td>
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<tr>
<td>PPIUD</td>
<td>Postpartum Intrauterine Device</td>
</tr>
<tr>
<td>SBCC</td>
<td>Social and Behavior Change Communication</td>
</tr>
<tr>
<td>TIPs</td>
<td>Trials of Improved Practices</td>
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<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
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Background

This document presents guidance for planning and implementing social and behavior change communication (SBCC) activities for postpartum family planning (PPFP), informed through global evidence and program learning. It also serves as an update to the Guide for Developing Family Planning Messages for Women in the First Year Postpartum, initially developed in 2010 by ACCESS-FP. In the years since the 2010 Guide was developed, the Maternal and Child Health Integrated Program (MCHIP), funded by the U.S. Agency for International Development (USAID), has built on the findings from ACCESS-FP. MCHIP has generated additional learning on successful strategies to enhance PPFP uptake that are integrated within broader maternal and child health program activities.

This updated guide features a refined set of principal PPFP behaviors, introduces key steps for how to design and implement SBCC for PPFP, and provides several case studies describing MCHIP’s work in this area. The guide draws from SBCC processes outlined in the C-Modules Learning Package developed under the C-Change Project and the Designing for Behavior Change curriculum developed by the CORE Group, and adapts them specifically for PPFP activities.

The intended audience for this guide is program managers and technical staff responsible for designing and implementing PPFP program activities, including international and local staff of nongovernmental organizations and representatives from ministries of health.

MCHIP has also developed a complementary e-Learning course on SBCC for PPFP, available here: http://reprolineplus.org/SBCC-PPFP-course.

WHAT IS SBCC FOR PPFP?

SBCC is defined as “the use of communication strategies—mass media, community-level activities, and interpersonal communication—to influence individual and collective behaviors that affect health.”\(^1\) Research shows that theory-driven, interactive communication that follows a proven design and implementation process can increase knowledge, shift attitudes and norms, and produce changes in a wide range of behaviors.\(^2\) Many implementers situate SBCC in a socio-ecological framework, which recognizes that determinants of health and health behavior exist on multiple levels and extend beyond the individual. Specifically, socio-ecological models acknowledge the influence of interpersonal relationships, community structures, and the broader environment.\(^3\)

PPFP focuses on voluntarily initiating use of family planning (FP) methods soon after a birth and continuously through the first two years postpartum. SBCC for PPFP aims to: 1) improve client knowledge and perceptions of PPFP; 2) increase the practice of recommended PPFP behaviors and use of services; 3) improve health worker knowledge, perceptions, and service delivery practices; and 4) increase community support, cultivating an “enabling environment” for PPFP, thereby helping couples to achieve healthy pregnancy spacing or limiting for those couples who have reached their desired family size.

\(^1\) https://www.fphighimpactpractices.org/sites/fphips/files/hip_healthcomm_brief.pdf.
Increasing PPFP uptake has valuable benefits for the lives of women, children, their families, and communities. Closely spaced pregnancies can pose serious health risks to mothers and their children. Interpregnancy intervals shorter than 18 to 24 months have been associated with an increased risk of preterm birth; low birth weight; fetal, early neonatal, and infant death; and adverse maternal health outcomes. In 2000, it was estimated that 90% of abortion-related deaths and 20% of deaths and illnesses that occurred during pregnancy or childbirth could have been prevented if women who wanted to delay or stop having more children had used FP. In countries with high birth rates and low contraceptive prevalence rates, if FP had been better promoted and women were able to access FP services, about one out of every three (32%) maternal deaths could have been avoided.

More than nine out of 10 women say that during their first year postpartum, they want to delay the next pregnancy for at least two years, or not get pregnant at all. However, despite the identified need for PPFP, a review of data from 17 countries highlights that major gaps exist between the total need for FP and its use during the first year postpartum in those countries. Studies also show that women desire to have information on PPFP right after giving birth. Strategic SBCC activities can address this desire for information, link women with PPFP services, and encourage supportive social norms. In fact, one of the high-impact practices for FP identified by USAID, UNFPA, and partners is to “implement a systematic, evidence-based health communication strategy that includes communication through multiple channels to enable people to make voluntary and informed health care decisions.”

**SPECIAL CONSIDERATIONS FOR POSTPARTUM WOMEN**

Postpartum women’s decisions to use contraception are determined by a unique set of factors. During the first year postpartum, women are often breastfeeding, they may have resumed sexual activity, and they experience a period of postpartum amenorrhea. After a pregnancy, the time before which a woman can become pregnant again will vary. Return to fecundity will depend on a number of factors, including her breastfeeding practices.

Factors affecting a woman’s perception of pregnancy risk (correctly or incorrectly) and use of contraception during the first year postpartum may include: understanding of factors affecting return to fecundity; resumption of sexual activity; awareness of contraceptive methods that can be safely used while breastfeeding; cultural beliefs and perceptions about engaging in sexual activity while still breastfeeding; and knowledge of the lactational amenorrhea method (LAM) and cues to transition to another modern method. Not surprisingly, these are not easy to quantify for scientists, much less for women who may not have access to such information. In many countries, women, their families, and sometimes even service providers lack knowledge about postpartum pregnancy risk and the importance of timely initiation of a modern contraceptive method. Misconceptions about the postpartum use of contraception are also prevalent, including the perception that all FP methods affect breast milk and may harm the

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child. In some countries, postpartum women are stigmatized if they seek out FP, given that social norms may dictate that women should wait until their infant reaches a certain age, or is walking before they return to sexual activity. Women may be concerned that their husbands will seek sexual favors outside the home, which may result in women returning to sexual activity earlier than social norms espouse. If these women are not using a FP method, they may be at risk for unplanned pregnancy. In seeking to increase uptake of PPFP, these special considerations and challenges should be addressed through the use of strategic approaches.

During pregnancy and through the first year postpartum, women tend to have more regular contacts with the health system, such as for antenatal, intrapartum, postnatal, and child health visits. These contacts provide an opportunity to ensure that all of the needs of the woman and child are met, including for FP. Figure 1 shows the various entry points for providing PPFP counseling and services during the antenatal, intrapartum, and extended postpartum periods.

**Figure 1: Opportunities for PPFP Counseling and Services across the Continuum of Care**

![Family Planning: Every Woman, Every Time](image)

It is very important to ensure that postpartum women have access to voluntary and informed choice of an FP method. Certain FP methods may be more suitable than others for women based on their breastfeeding status and timing postpartum, and these considerations should be kept in mind during PPFP counseling.
MCHIP has identified seven principal PPFP behaviors that need to be addressed to increase PPFP uptake and build a supportive environment for PPFP. The selection of these seven behaviors was informed by global evidence and program learning under MCHIP and other projects. This list is updated from the initial list of key behaviors identified under ACCESS-FP.

The seven principal behaviors are presented in Figure 2. Each of the behaviors is also described in greater detail, along with illustrative behavioral determinants, activities, and key messages in Table 3 on page 21.

**Figure 2: The Principal PPFP Behaviors**

1. **Couple Communication**
   - Couples discuss FP together, including family size and whether and when to have another child.

2. **Healthy Spacing of Pregnancy**
   - Women/couples wait at least 2 years after a live birth or 6 months after a miscarriage or abortion before starting another pregnancy, if desired.

3. **Immediate and Exclusive Breastfeeding**
   - Women breastfeed immediately after delivery and exclusively for 6 months.

4. **Seek PPFP during Health Contacts**
   - Women/couples discuss PPFP options suitable to breastfeeding status and timing postpartum with a health worker during antenatal, birth, postnatal, and child health contacts.

5. **Know Pregnancy Risk, Initiate PPFP Use**
   - Women/couples use an FP method before they are at risk of pregnancy after delivery, and continue to use it for 2 or more years. Couples who do not want another pregnancy consider options for limiting future pregnancies.

6. **LAM + Transition**
   - Women who use LAM breastfeed exclusively for up to 6 months as long as menstruation has not returned, and then transition to another modern method once their child reaches six months, or upon introduction of other foods/liquids if earlier than 6 months.

7. **PPFP Champions**
   - Champions discuss the benefits of healthy timing and spacing of pregnancy, PPFP, and LAM with others in the community.
These behaviors are geared toward childbearing women and couples, given that their practice of recommended behaviors is what will ultimately achieve desired FP and broader health outcomes. However, the sustained practice of these behaviors by women and couples also usually requires promoting shifts in knowledge, perceptions, and behavior among other individuals who influence their practice of optimal behaviors, including health providers, community leaders, husbands, and other family members. Creating an “enabling environment” for optimal PPFP behaviors also requires addressing factors that may facilitate or hinder adoption of recommended practices, including “national policies and legislation, political forces, prevailing economic conditions, the private sector, religion, technology, and the natural environment.”

Taking an ecological view of SBCC for PPFP can help demonstrate the many layers of influence on PPFP practices (see Figure 3). At the individual level in the center of the model, a woman’s use of FP after giving birth may be affected by her past experiences and understanding of when her fecundity returns. The partner and family layer that surrounds the individual layer depicts the influence of her partner’s views and whether the couple can communicate effectively together about PPFP, as well as the views and influence of extended family members. At the health worker and system layer, women’s practice of optimal behaviors may be influenced by factors such as availability of providers trained in PPFP counseling and service provision, quality of PPFP counseling, and contraceptive availability. Social norms and the views of influential community members may also hinder or facilitate a woman’s motivation to seek PPFP services. At the policy level, PPFP standards and policies help facilitate the systematic and standardized provision of PPFP services at community and facility levels. Creating an enabling environment for behavior change requires addressing barriers and motivating factors at each level. These factors vary by context.

**Figure 3: An Ecological View of Factors Influencing the Practice of Optimal PPFP Behaviors**

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9 [https://c-changeprogram.org/sites/default/files/sbcc_module0_intro.pdf](https://c-changeprogram.org/sites/default/files/sbcc_module0_intro.pdf).
Steps for Planning and Implementing SBCC for PPFP

Most health communication programs employ a planning model or framework that guides design, implementation, and evaluation. All of these models share some basic assumptions and most recommend a similar process. The C-Planning Process, developed by the C-Change project, is a well-known SBCC framework. The C-Planning Process has the following five key steps: 1) Understanding the Situation; 2) Focusing and Designing; 3) Creating; 4) Implementing and Monitoring; and 5) Evaluating and Replanning.

The sections that follow highlight key considerations for PPFP activities at each of the five stages. For the purpose of this guide, considerations for Steps 4 (Implementing and Monitoring) and 5 (Evaluating and Replanning) will be presented together in one section.

STEP 1: UNDERSTANDING THE SITUATION

The process of planning SBCC activities for PPFP requires understanding the current status of PPFP behaviors within a specific population, the factors influencing the practice of these behaviors, and the communication channels through which members of the population communicate and receive information. Gathering this information requires reviewing existing documentation as well as conducting formative assessment, as described below.

Review existing documentation to understand the current situation of PPFP in the target site(s)

Examine PPFP/FP policies, standards and materials already developed within the country. Review existing studies and reports, including Demographic and Health Survey (DHS) data, to learn more about each of the PPFP behaviors of interest (see PPFP behaviors presented in Figure 2). Key areas to explore in the review of existing documentation include the following:

- Coverage/reach of PPFP services
- Current contraceptive prevalence and contraceptive method mix (disaggregated for women within the first year postpartum, if possible)
- Birth intervals

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10 The C-Planning Process was developed by the C-Change Project. It is an adapted version of the P-Process, which was initially developed in 1982 by the Johns Hopkins Center for Communication Programs and its partners in the USAID-supported Population Communication Services (PCS) project.
• Reasons for non-use of FP
• Breastfeeding practices (duration, frequency)
• Influencing groups for use of PPFP (e.g., partners, mothers/mothers-in-law, religious and community leaders, health workers, etc.)
• Platforms for reaching postpartum women with information and services (e.g., antenatal care [ANC], facility births, postnatal/child health visits, immunization sessions, nutrition/feeding programs, community health worker [CHW] home visits, etc.)
• Previous activities conducted within the target sites on PPFP/FP

MCHIP has conducted re-analyses of DHS data from selected countries to tease out special considerations for PPFP. These reports provide helpful background resources to inform the development of PPFP activities, and are available here: http://www.k4health.org/toolkits/ppfp/dhs-analyses.

Conduct Formative Assessment

Formative assessment processes aim to provide an understanding of current knowledge, perceptions, and practices related to PPFP, and to identify key barriers and motivating factors that affect the practice of optimal PPFP behaviors. Formative assessments help to fill in the gaps from the initial literature and program review. Formative assessment approaches used may include the following:

• In-Depth Interviews: Usually conducted face-to-face with one interviewer and one respondent, designed to explore an individual’s perspective about PPFP. Participants may be asked about their knowledge and perceptions of PPFP, past experience with PPFP use, current PPFP practices, and barriers and motivating factors for use of PPFP services.

• Focus Group Discussions (FGDs): A facilitated discussion on PPFP with a group of participants, such as pregnant or postpartum women, husbands/partners, other family members, community leaders, and FP service providers.


• Trials of Improved Practices (TIPs): Allows program planners to pre-test practices that a program will promote. Individuals or families try out the proposed practices and their feedback is used for designing program activities and communication messages. Learn more about TIPs here: http://www.manoffgroup.com/approach_developing.html. MCHIP has successfully applied the TIPs approach for infant and young child nutrition practices in Egypt and for an integrated PPFP and nutrition program in Yemen.

• Barrier Analysis (BA): A rapid assessment tool designed to help identify factors that influence whether or not a behavior is adopted. The process involves comparing individuals who practice the desired behavior with those who do not practice the desired behavior, along a number of different behavioral domains. Learn more about BA here: http://barrieranalysis.fhi.net/what_is/what_is_barrier_analysis.htm. Examples of how BA has been applied to LAM and the transition to other modern contraceptive methods in Bangladesh can be found here: http://www.k4health.org/toolkits/ppfp/lam-and-transition-barrier-analysis-sylhet-district-bangladesh and in Guinea and Uganda can be found here:

11 Use caution in assuming that this information automatically applies to a given priority group, unless it is backed by reliable research.

- **Health Facility Assessments**: Can be used to explore service delivery processes, costs, commodity availability, service utilization, quality, and opportunities for integrating PPFP. Specific health facility assessment methods are described here: https://www.k4health.org/sites/default/files/5%20Measure%20Facility%20Assessment%20Methods%202009.pdf

- **Social Network Analysis**: Can be used to examine the spread of influence of FP information through social networks to assess the role of social networks in motivating or hindering FP adoption and use. An example of how a social network has been applied for FP is available here: http://irh.org/wp-content/uploads/2014/03/TJ_Using_Network_Analysis_Social_Change_FINAL.pdf.

- **Participatory Learning and Action (PLA)**: an approach that actively engages community members to identify community problems and plan solutions.

Regardless of the formative assessment method(s) selected, the domains listed below should be explored, given that they will be important in developing the strategic design of activities, messages, and materials. These domains should be explored not only among current/future PPFP users, but also among other influencers of PPFP behaviors such as health care providers, husbands, and community leaders.

**KNOWLEDGE**

- **PPFP knowledge**— What is respondents’ knowledge of recommended birth-to-pregnancy intervals, postpartum return to fecundity and pregnancy risk after delivery, LAM criteria and cues to transition, recommended breastfeeding practices, and contraceptive methods suitable for postpartum women based on breastfeeding status and timing postpartum?

**PERCEPTIONS**

- **Susceptibility/Risk of Pregnancy**: During the period after childbirth, do women see themselves as being at risk of pregnancy?

- **Positive Consequences/Benefits of healthy pregnancy spacing and using PPFP**: What do respondents see as the positive outcomes associated with longer birth to next pregnancy intervals and postpartum use of modern contraceptive methods?

- **Negative Consequences of healthy pregnancy spacing and using PPFP**: Do respondents perceive that there are benefits associated with closely spaced births or large family size?

- **Perceived Severity**: Do respondents perceive that unplanned and closely spaced pregnancies are a serious problem? What do respondents see as the negative outcomes?

- **Perceived Action Efficacy**: Do respondents believe that modern family planning methods are effective in preventing unplanned and closely spaced pregnancies?

- **Self-Efficacy**: Do respondents think they have the power or skills to use family planning after childbirth? Do they believe they have the power or skills to discuss PPFP with their spouse or with a health worker?

- **Social Norms Surrounding PPFP**: Within the community, which individuals and groups approve of PPFP? Which individuals and groups disapprove?
• **Culture:** What do respondents see as prevailing views and traditions in their communities related to use of contraception during the extended postpartum period? Is there stigma around the use of FP during the extended postpartum period?”

**PRACTICES**

• **Current PPFP practices**— What are the current PPFP practices in the community? When do couples return to sexual activity after childbirth? How much and for what duration do women breastfeed? How long after childbirth do women/couples generally start using an FP method? What methods are preferred? Is it common for couples to communicate about PPFP and their reproductive intentions? Is polygamy practiced?

**OTHER DOMAINS**

• **Access to PPFP services**— Do respondents have access to quality PPFP services during ANC, childbirth, and at other service delivery points during the first year after childbirth? Are providers adequately trained in PPFP service provision? Are contraceptives available, or are there stock-outs of certain methods?

• **Communication channels**— Through which communication channels do respondents learn about and discuss PPFP? Who do they trust most for information on this topic (service providers, mothers-in-law, religious leaders, or others)?

**STEP 2: FOCUSING & DESIGNING**

When designing SBCC for PPFP, it is important to ensure that the activities implemented are targeted to the needs of the population, and that they actually address the factors which most motivate or make it challenging for individuals to practice the recommended PPFP behaviors. The Focusing and Designing phase involves using findings from the Understanding the Situation phase to inform the development of a SBCC strategy to guide program implementation.

**The Designing for Behavior Change Framework**

To assist with the preparation of a SBCC strategy, it can be helpful to first complete the Designing for Behavior Change (DBC) Framework, which was developed by the CORE Group and is a useful tool for aligning formative assessment findings with the selection of appropriate objectives and activities. The DBC Framework template is presented in Figure 4.

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Figure 4: Designing for Behavior Change Framework

Program Objective: _______________________________________

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Priority or Influencing Group</th>
<th>Determinants</th>
<th>Bridges to Activities</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>To promote this behavior:</td>
<td>Among this audience:</td>
<td>We will research these determinants: (Circle one)</td>
<td>And address these bridges to activities (priority benefits and priority barriers):</td>
<td>By implementing these activities:</td>
</tr>
<tr>
<td></td>
<td>(Circle one)</td>
<td>(Circle the most powerful)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influencing Group:</td>
<td></td>
<td>*These can only be determined after conducting qualitative research</td>
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<td></td>
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</tbody>
</table>

Based on findings from formative assessment, program planners complete the DBC framework by identifying:

- **Behavior:** Which PPFP behavior(s) are you trying to promote? *(See Figure 2.)* Within PPFP programs, it is recommended that all seven behaviors be addressed, although some may be emphasized more than others depending on gaps identified during the formative assessment. If there are not sufficient resources available to tackle all seven behaviors, programs may also choose to prioritize a more limited set of behaviors. For example, if you find widespread gaps in couples’ communication about reproductive intentions, you may choose to prioritize activities that target Behavior 1: Couple Communication.

- **Priority group:** Priority groups are those who practice the desired PPFP behavior. Influencing groups are those who have an important role in influencing whether or not individuals in the priority group practice the desired PPFP behavior. In PPFP programs, the **priority group** is often antenatal women, postpartum women, or husbands/partners. Specific sub-populations within groups may require specially tailored approaches, such as high parity women/couples, adolescents, or individuals with specific health concerns. Influencing groups may include mothers, mothers-in-law, health workers, husbands, religious and community leaders, and friends/neighbors.

You will fill out the DBC framework separately for each behavior and priority group, identifying the unique determinants and bridges to activities specific to that behavior and group.

• **Determinants:** Determinants are factors which influence why a specific population would practice or might not practice a specific behavior (e.g., perceived self-efficacy, perceived social norms, perceived positive/negative consequences, access, cues for action, perceived susceptibility/severity, policy, culture, perceived action efficacy, divine will). Determinants can only be revealed through formative research.

• **Bridges to Activities:** Bridges to activities are a link between the determinant and the activity—a determinant is what you want to change and the bridge is how (in what direction) you will address it. Bridges are more specific than determinants, and tell you whether you will “increase, improve, or decrease” something. Bridges to activities can also be thought of as the results or outcomes that each activity seeks to achieve. For example, if one of the main determinants of the behavior is “perceived susceptibility to pregnancy,” one of the bridges might be “increasing knowledge that women may become pregnant prior to menses return.” If the main determinant of the behavior is “perceived negative effects of using FP” then the bridge may be “increasing awareness that there are FP methods that are safe and healthy for postpartum women and their infants.” There should always be at least one “Bridge to Activity” written for each Determinant. *(See Figure 5 below.)*

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**Figure 5: From Determinants to Bridges to Activities**

<table>
<thead>
<tr>
<th>DETERMINANT</th>
<th>BRIDGE TO ACTIVITY</th>
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</thead>
<tbody>
<tr>
<td>Perceived susceptibility to pregnancy</td>
<td>Increasing understanding that women may become pregnant prior to menses return</td>
</tr>
<tr>
<td>Perceived negative effects of using FP</td>
<td>Increasing awareness that there are FP methods that are safe and healthy for breastfeeding women and their infants</td>
</tr>
</tbody>
</table>

• **Activities:** Activities should help to advance each of the bridges to activities identified in the previous column. They should be specific to the audience, and designed to maximize benefits and minimize barriers to practicing the behavior. Consider including activities which offer opportunities for participatory dialogue and reflection and which encourage community involvement in and ownership of the change process. Communicating through multiple channels (rather than just one) will enhance your approach. Table 1 presents examples of activities by communication channel. Further ideas for SBCC activities to address each of the seven PPFP behaviors can be found in Table 3 on page 21.
Table 1: Sample Communication Channels and Activities to Consider

<table>
<thead>
<tr>
<th>Communication Channel</th>
<th>Examples of Activities</th>
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<tbody>
<tr>
<td><strong>Mass Media Channels</strong></td>
<td></td>
</tr>
<tr>
<td>Broadcast (television or radio at national or regional level)</td>
<td>- Public service announcements (PSAs), commercials</td>
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<td></td>
<td>- Talk shows</td>
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<td></td>
<td>- Call-in shows (for example, “ask the expert” shows, contests)</td>
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<td></td>
<td>- Documentaries / testimonials</td>
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<td></td>
<td>- Serial dramas</td>
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<td>- Situation comedies</td>
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<td>- Magazine or variety shows</td>
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<td></td>
<td>- Animated cartoons</td>
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<td>- Music videos</td>
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<td></td>
<td>- Songs and jingles</td>
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<td></td>
<td>- Celebrity endorsements</td>
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<tr>
<td>Print media</td>
<td>- News coverage and advertising in newspapers and magazines</td>
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<td></td>
<td>- Direct mail</td>
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<tr>
<td></td>
<td>- Decision-making aids for clients and providers</td>
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<tr>
<td></td>
<td>- Comic books, photonovelas (a comic book-like form that uses photos to tell a dramatic story)</td>
</tr>
<tr>
<td></td>
<td>- Pamphlets, fliers</td>
</tr>
<tr>
<td></td>
<td>- Posters, billboards</td>
</tr>
<tr>
<td>Information and Communication Technology</td>
<td>- Internet websites, social media, distance learning</td>
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<tr>
<td></td>
<td>- Mobile phone programs</td>
</tr>
<tr>
<td><strong>Interpersonal Channels</strong></td>
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<tr>
<td>Between provider and client, parent and child, or among peers</td>
<td>- Telephone hotline</td>
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<td></td>
<td>- Client counseling</td>
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<td></td>
<td>- Instruction</td>
</tr>
<tr>
<td><strong>Community-Based Channels</strong></td>
<td></td>
</tr>
<tr>
<td>Community mobilization, group interaction</td>
<td>- Community discussion groups, peer support groups, listening groups, workplace groups</td>
</tr>
<tr>
<td>Outreach activities by program staff or community members</td>
<td>- Community, village-to-village</td>
</tr>
<tr>
<td></td>
<td>- Household</td>
</tr>
<tr>
<td></td>
<td>- Peer-to-peer</td>
</tr>
<tr>
<td>Live performances</td>
<td>- Street theater</td>
</tr>
<tr>
<td></td>
<td>- Puppet shows</td>
</tr>
<tr>
<td></td>
<td>- Talent shows</td>
</tr>
<tr>
<td></td>
<td>- Contests (talent, art or dance)</td>
</tr>
<tr>
<td>Community media</td>
<td>- Community newspapers</td>
</tr>
<tr>
<td></td>
<td>- Local radio</td>
</tr>
</tbody>
</table>

Adapted from: [http://www.k4health.org/sites/default/files/commforbetterhealth.pdf](http://www.k4health.org/sites/default/files/commforbetterhealth.pdf)

A sample DBC Framework for one specific behavior and priority group is presented in Figure 6. The template includes an illustrative PPFP example to demonstrate how to fill out the table; however, it should be noted that an actual DBC framework would include more detail, and a separate table would be filled out for each priority behavior of focus and audience targeted within the project.
Figure 6: An Illustrative PPFP Example of the Designing for Behavior Change Framework

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Priority or Influencing Group</th>
<th>Determinants</th>
<th>Key Factors</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>To promote this behavior: Postpartum women select an FP method and initiate use before they are at risk of pregnancy after delivery, and continue to use it for 2 or more years (FP Behavior #5)</td>
<td>Among this audience: (Circle one)</td>
<td>We will research these determinants: (Circle the most powerful)* Access, Self-Efficacy, Perceived Social Norms, Perceived Positive Consequences, Perceived Negative Consequences, Perceived Severity, Perceived Susceptibility, Action Efficacy, Perception of Divine Will, Cues for Action *These can only be determined after conducting qualitative research</td>
<td>And address these key factors (priority benefits and priority barriers):</td>
<td>By implementing these activities:</td>
</tr>
<tr>
<td>Priority Group: Liberian women within the first 2 years postpartum</td>
<td>Influencing Group: Peers Spouses Health Providers</td>
<td></td>
<td>1. Increasing social acceptability and support for PPFP among female peers</td>
<td>1. Train service providers on PPFP; encourage service providers to address women’s concerns and discuss availability of contraceptive options which will not harm the breast milk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Increasing understanding that there are contraceptive methods suitable for breastfeeding women that will not harm the breast milk</td>
<td>2. Incorporate discussions on return to fecundity and pregnancy risk after delivery within breastfeeding support groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Increasing understanding that women may become pregnant prior to menses return</td>
<td></td>
</tr>
</tbody>
</table>

Source: [http://www.k4health.org/sites/default/files/commforbetterhealth.pdf](http://www.k4health.org/sites/default/files/commforbetterhealth.pdf)

More information about how to use DBC is available here:

**PREPARING AN SBCC STRATEGY**

Once the DBC framework has been prepared, an **SBCC strategy** should be developed, in which you will further detail the proposed activities listed in the framework and describe how you will implement and evaluate the planned activities. Your SBCC strategy will likely need to be updated based on findings from field testing and program implementation. There are a number of different ways that you can structure your SBCC strategy, but strategies generally include the following key components:

- **Situation Analysis:** provides a summary of findings from Step 1: Understanding the Situation
- **Behavior Change Objectives:** describes the PPFP behaviors you will address and the changes you hope to see; draws from the “bridges to activities” identified in the DBC framework
- **Strategy Description:** includes a detailed description of communication channels, activities, messages, and materials
- **Implementation or Management Plan:** describes key inputs, roles, and timeline for completing activities
- **Evaluation Plan:** describes key indicators and evaluation strategy

Additional guidance on how to prepare communication strategies is available here:

**STEP 3: CREATING**

After preparing the communication strategy, this step in the process involves: developing content outlined in the SBCC strategy; pre-testing concepts, messages and materials; and revising the content to incorporate findings.

First, you will refine the activity concepts developed during the Focusing and Designing phase. Then you will begin to develop messages and materials to be incorporated within the activities. Keep in mind that content should be:

- Accurate and comprehensible
- Attractive to the intended audience
- Tailored to address barriers and motivators faced by specific groups
- Appropriate in tone (e.g. supportive, friendly, humorous, authoritative, medical)
- Geared toward local literacy levels, using local terminology
- Consistent with other program communications
- Sensitive to local customs and values

**Table 3 on page 21** presents key information related to each of the seven behaviors which can be adapted into context-specific messages and incorporated across program activities. It is important to ensure that messages are strategically framed to resonate with the intended audience. Remember, though, that it generally takes more than a message or printed materials to promote behavior change. Consider not only opportunities to share information, but also to engage individuals in dialogue, reflection, and learning.

SBCC tools and materials developed to support your PPFP activities may include the following:

- **Counseling cards:** Counseling cards may be used by CHWs or service providers to help explain PPFP concepts. They often include an image on one side of the card and key discussion points on the other side. An example of PPFP counseling cards developed for use by CHWs in Kenya is available here: [https://www.k4health.org/sites/default/files/kenya_miycn-fp_counselling_cards_final_0.pdf](https://www.k4health.org/sites/default/files/kenya_miycn-fp_counselling_cards_final_0.pdf). Balanced Strategy Counseling Plus counseling cards for FP are also available here: [http://www.popcouncil.org/uploads/pdfs/2012RH_BCSPlusCounselingCards.pdf](http://www.popcouncil.org/uploads/pdfs/2012RH_BCSPlusCounselingCards.pdf).
• **Job aids for health providers:** Job aids help to ensure consistency and accuracy of information shared by service providers and CHWs during their contacts with postpartum women. A job aid developed to enable vaccinators to refer postpartum women for FP services in Liberia is available here: [https://www.k4health.org/sites/default/files/MCHIP%20Liberia%20Job%20Aid.pdf](https://www.k4health.org/sites/default/files/MCHIP%20Liberia%20Job%20Aid.pdf).

• **Leaflets:** Leaflets may be provided to clients to help reinforce key information discussed during counseling or community activities. Leaflets can also offer a helpful starting point for women to initiate conversations about PPFP with spouses or other family members. An example of a FP leaflet designed for postpartum women in Liberia is available here: [https://www.k4health.org/sites/default/files/MCHIP%20Liberia%20Brochure.pdf](https://www.k4health.org/sites/default/files/MCHIP%20Liberia%20Brochure.pdf).

• **Posters:** Posters may also help to reinforce information shared by service providers or CHWs. An example of a PPFP poster developed to promote exclusive breastfeeding (EBF) and the use of LAM in Kenya is available here: [https://www.k4health.org/sites/default/files/kenya_miycn-fp_poster_final_0.pdf](https://www.k4health.org/sites/default/files/kenya_miycn-fp_poster_final_0.pdf).

• **Group discussion guides:** Group discussion guides can be developed to support CHWs or community champions to facilitate discussion of PPFP. They may include suggested discussion topics and illustrative questions to spark conversation.

• **Fictional stories:** Fictional stories can be used to spark reflection and dialogue about PPFP. For example, in Bangladesh, through the Healthy Fertility Study, “Asma’s Story” was shared and discussed during home visits and community discussion sessions. Asma’s Story told how one woman (“Asma”) incorrectly assessed her risk of pregnancy to be minimal in the months before her menstruation returned. Asma said she would wait until her menstruation returned before starting a modern FP method, but then became pregnant. She learned that conception can occur before menstruation returns, and that it is important to start using an FP method soon after giving birth. An article detailing findings from an assessment of Asma’s Story is available here: [http://www.pec-journal.com/article/S0738-3991%2814%2900378-4/abstract](http://www.pec-journal.com/article/S0738-3991%2814%2900378-4/abstract).

• **Interactive games:** Interactive games may also be developed to facilitate individual reflection or group discussion about PPFP.

• **Sermon guides:** Sermon guides can assist religious leaders to communicate about healthy timing and spacing of pregnancy and PPFP within their communities. These guides often highlight specific excerpts from religious texts which support or do not explicitly oppose FP. In Liberia, for example, MCHIP developed a sermon guide for religious leaders outlining the benefits of FP for maternal and child health. More information about this initiative is available here: [http://www.mchip.net/node/2331](http://www.mchip.net/node/2331).

• **Radio spots:** Radio is a popular communication channel in many places around the world. Radio dramas or informational spots can be used to increase knowledge and build social support for PPFP.

• **Television spots:** Where households have access to television, television programs on PPFP can be developed and aired. These programs may be presented as dramas/edutainment and may have accompanying viewing and discussion group components.

• **SMS:** Mobile phones and tablets have become an increasingly popular communication mechanism worldwide. The MAMA Alliance has developed SMS messages on maternal, newborn, and child health (MNCH) and FP that can be adapted to specific sites: [http://www.mobilemamaalliance.org/mobile-messages](http://www.mobilemamaalliance.org/mobile-messages).
• **Community theater:** Many cultures have strong dramatic traditions and community theater provides a popular means of local entertainment. Local drama troops can be engaged to prepare a skit about PPFP, and engage community members in discussion about the content. [http://www.path.org/projects/community_theater_benin.php](http://www.path.org/projects/community_theater_benin.php)

• **Community video:** Locally produced videos on MNCH and FP can be prepared, screened in small or large groups, and followed by a facilitated discussion. A Community Video for Social Change Toolkit is available here: [http://www.arcrelief.org/site/PageServer?pagename=videoforsocialchange_toolkit](http://www.arcrelief.org/site/PageServer?pagename=videoforsocialchange_toolkit)

**Pre-Testing**

All concepts and materials developed should be pre-tested prior to finalization. Pre-testing is a process to solicit feedback on the materials from the priority and influencing groups, and helps to ensure that materials are appropriate, comprehensible, acceptable, and motivational for the target group. Pre-testing may be conducted through individual interviews or FGDs. Detailed guidance on pre-testing can be found here: [http://www.fsnnetwork.org/sites/default/files/conducteffectivepretestenhv.pdf](http://www.fsnnetwork.org/sites/default/files/conducteffectivepretestenhv.pdf).
STEPS 4 AND 5: IMPLEMENTING, MONITORING, EVALUATING, REPLANNING

Key Implementation Considerations

Once the planning and pre-testing have been completed, implementation of SBCC activities can begin. As you begin the implementation process, consider factors which may influence the success of your activities, such as:

- **Availability of Contraceptive Supply:** Ensure that a sufficient supply of contraceptives is available to meet increased demand for family planning services generated by your activities. Work with key stakeholders (e.g. facility in-charge, sub-national, and national teams) to ensure that they are aware of the projected increase in demand for contraceptives and that sufficient supply chain mechanisms are in place. The DELIVER Project website houses a number of useful tools for strengthening contraceptive supply chains: [http://deliver.jsi.com/dhome/resources/tools/printedtools/fpprintedtools](http://deliver.jsi.com/dhome/resources/tools/printedtools/fpprintedtools).

- **Availability of Quality PPFP Services:** When working to stimulate demand for services—either through community mobilization or referral within the health facility—it is important to ensure that women who are interested in PPFP receive quality PPFP counseling and services including access to a diverse contraceptive method mix. PPFP services involve reaching out to women during pregnancy, intrapartum, and through contacts with the health system during the first year postpartum. FP service providers should be sufficiently trained in PPFP standards and provided with a checklist of skills that are integrated with other maternal and infant care services. Their performance should be monitored on a regular basis. Job aids may also help to promote consistent and accurate PPFP counseling.

- **Consistent Supportive Supervision:** Regular supportive supervision should be conducted to monitor whether SBCC for PPFP activities are being implemented as designed. During supportive supervision visits, supervisors and project staff can work with field staff to identify accomplishments and challenges, and develop plans of actions to address performance gaps.

- **Involvement of SBCC Expertise:** Involvement of SBCC experts in program design and implementation helps to ensure that program activities are aligned with best practices in SBCC. While working on SBCC for PPFP activities, work to strengthen the SBCC capacity of national and local stakeholders and institutions.

- **Strong Stakeholder Support:** Building strong stakeholder support for SBCC activities is key to ensuring local ownership and sustainability of activities. In addition to involving local, sub-national, and national stakeholders, consider involving the team responsible for health promotion activities within the Ministry of Health and other local organizations with SBCC expertise in planning and implementation efforts.

- **Process Evaluation:** Process evaluations and/or routine M&E can help to identify any concerns or areas where adjustments to the approach are needed.

Additional guidance on SBCC partnerships and staffing, implementation coordination, supervision, and budgeting can be found in the C-Modules Learning Package here: [http://www.e-hubonline.org/sites/default/files/resources/main/Module4-Practitioner.pdf](http://www.e-hubonline.org/sites/default/files/resources/main/Module4-Practitioner.pdf). These
tools are designed to be used across technical areas and could easily be adapted for PPFP activities.

**Monitoring Considerations**

As you monitor the implementation of your activities, consider the following important questions:

- Is program implementation occurring as intended?
- Are PPFP communication tools and materials being used as designed?
- What is the level of client/community member participation in PPFP activities?
- Do clients/community members remember key information related during counselling and community activities?
- Has the team noted any adverse events which have compromised individuals’ safety, confidentiality, or well-being?
- What implementation challenges is the team facing?
- Have there been any changes in FP uptake among postpartum women in the project sites?
- What barriers continue to prevent women from practicing the recommended behaviors?
- How satisfied are service providers and clients/community members with program activities?

While monitoring program activities, keep an eye out for “red flags,” or areas for concern. Red flags may include FP commodity stockouts, inappropriate or nonuse of SBCC tools/materials, providers routinely demonstrating gaps in PPFP knowledge/counseling, and expressions of concerns from clients about lack of privacy or confidentiality. Addressing red flags may require adjusting the approach, re-training staff, and engaging new stakeholders. If activities are being implemented as designed and the intended audience is being reached, but PPFP behaviors are not changing, it may be necessary to revisit the formative assessment findings and reassess the activities selected. Additional formative assessment may be needed to better understand remaining barriers to behaviour change.

**Data Sources**

Sources of data for monitoring and evaluating SBCC for PPFP activities may include FP registers, health information systems, household surveys, pre-/post-tests, supervision checklists, interviews and focus group discussions, client observation, exit interviews, participatory monitoring and evaluation methods, and clinical vignettes.

**Indicators of Success**

Ultimately, the aim of SBCC for PPFP is to help women and couples realize their reproductive intentions and improve healthy pregnancy spacing to reduce adverse MNCH outcomes. Other indicators of success may include improved PPFP counseling skills by providers, improved knowledge of PPFP (including return to fecundity and LAM + transition), increased demand for PPFP services, increased community dialogue around PPFP, reductions in misconceptions around PPFP, and positive shifts in social norms related to PPFP. To attain this information, both qualitative and quantitative approaches are needed.

Qualitative research provides descriptive information and can be used to help provide insight into how well program activities are running and to identify remaining barriers to success. It can also provide insight into perceptions of the community about progress toward program goals. Qualitative methods may rely on in-depth interviews and FGDs as well as client observation and participatory evaluation methods. Quantitative methods and tools such as FP registers at facility level and structured household surveys at the community level allow programs to monitor
processes and outputs as well as evaluate outcomes. A longer list of general PPFP program indicators can be found on the [K4H PPFP Toolkit](https://www.k4health.org/sites/default/files/PPFP%20Indicators%2015Dec2010%20(2).pdf).

Illustrative indicators for monitoring and evaluating PPFP SBCC activities can be found in Table 2.

Table 2: Illustrative Indicators for Monitoring and Evaluating SBCC for PPFP Activities

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INPUT/OUTPUT (Monitoring Indicators)</strong></td>
<td></td>
</tr>
<tr>
<td>What has been done—when, where, how, and who was reached?</td>
<td></td>
</tr>
<tr>
<td># of health providers (facility and community) trained on PPFP counseling and service provision</td>
<td>Program records</td>
</tr>
<tr>
<td>#/% of service delivery points offering PPFP counseling and services</td>
<td>Program records</td>
</tr>
<tr>
<td>#/% of service delivery points that have PPFP client information, education, and communication (IEC) materials available</td>
<td>Routine monitoring data collected during supportive supervision</td>
</tr>
<tr>
<td># of PPFP leaflets/IEC materials distributed</td>
<td>Program records</td>
</tr>
<tr>
<td>#/% of clients who are counseled or reported being counseled on PPFP during a visit to the health facility, by service delivery site</td>
<td>Health facility registers, exit interviews</td>
</tr>
<tr>
<td>#/% of women who discussed or reported discussing FP with a CHW during a home visit in the last 12 months</td>
<td>CHW health registers, exit interviews</td>
</tr>
<tr>
<td># of women referred to a facility for PPFP by a trained CHW</td>
<td>CHW health registers</td>
</tr>
<tr>
<td># of PPFP SBCC activities held, by type of activity</td>
<td>CHW activity records</td>
</tr>
<tr>
<td># of individuals in program-supported areas who participated in PPFP SBCC activities, by type of activity</td>
<td>CHW activity records</td>
</tr>
<tr>
<td>#/% of service providers meeting counseling standards</td>
<td>Routine monitoring data collected during supportive supervision</td>
</tr>
<tr>
<td><strong>OUTCOME INDICATORS</strong></td>
<td></td>
</tr>
<tr>
<td>How much did knowledge, attitudes, and behavior change?</td>
<td></td>
</tr>
<tr>
<td>#/% of women aged 15–49 (or other respondent groups) who know that a woman should wait at least 24 months after the woman gives birth before attempting to become pregnant again</td>
<td>Client exit interview, household survey</td>
</tr>
<tr>
<td>#/% of women aged 15–49 (or other respondent groups) who know that a woman should wait at least six months after a miscarriage or abortion before attempting to become pregnant again</td>
<td>Client exit interview, household survey</td>
</tr>
<tr>
<td>#/% of postpartum women who know pregnancy can occur prior to menses return</td>
<td>Client exit interview, household survey</td>
</tr>
<tr>
<td>#/% of antenatal/postpartum women who report having discussed FP with their spouse</td>
<td>Client exit interview, household survey</td>
</tr>
<tr>
<td>#/% of women aged 15–49 who report intending to wait at least two years after their last birth to get pregnant again</td>
<td>Client exit interview, household survey</td>
</tr>
<tr>
<td>#/% of individuals in program-supported areas who can accurately recall a project-supported message/jingle</td>
<td>Household survey</td>
</tr>
<tr>
<td>#/% of women aged 15–49 (or other respondent groups) who can recall LAM criteria</td>
<td>Client exit interview, household survey</td>
</tr>
<tr>
<td># of new contraceptive users at program sites, disaggregated by postpartum status (0–12 months)</td>
<td>FP registers</td>
</tr>
<tr>
<td># of continuing contraceptive users at program sites</td>
<td>FP registers</td>
</tr>
<tr>
<td>#/% of postpartum women who exclusively breastfeed their children for the first six months</td>
<td>Household survey</td>
</tr>
</tbody>
</table>
Monitor input/output indicators on a regular basis to ensure that your activities are proceeding as planned and make adjustments to your implementation activities as needed.

To evaluate program activities, develop M&E questions and indicators related to your activities and SBCC objectives. Finally, disseminate your findings to key stakeholders, reflect on findings, and identify opportunities for revising the approach to strengthen and enhance outcomes. Identify steps for sustaining and scaling up successful approaches.
An Illustrative Application: Key Behaviors, Activities, and Messages

Table 3 presents the seven principal PPFP behaviors, along with potential barriers that women/couples may face in practicing the particular behavior, illustrative activities, and key information for clients. This information can be adapted into context-specific messages incorporated across program activities. This is an illustrative list intended as a reference to spark thinking about programming in this area, and is not intended as a prescriptive list. The potential barriers, illustrative activities, and key information presented here are informed by global guidance and MCHIP’s field learning in numerous countries. Please note that this table is NOT the same as the DBC Framework, given that the table illustrates key information for clients and is a global reference rather than context specific.

Table 3: SBCC for PPFP: An Illustrative Application

<table>
<thead>
<tr>
<th>PPFP Behavior</th>
<th>Potential Barriers</th>
<th>Illustrative Activities</th>
<th>Key Information for Clients (to be adapted into context-specific messages)</th>
</tr>
</thead>
</table>
| **1. COUPLE COMMUNICATION:**
  - Couples discuss FP together, including ideal family size and whether and when to have another child. | Partner opposition (real or perceived)  
Absent partner  
Lack of knowledge regarding recommended birth-to-pregnancy intervals and PPFP options  
Society values large families | Offering and promoting couple-friendly FP services  
Health promotion activities encouraging men to accompany wives for FP counseling  
Male engagement activities such as discussion groups  
Engagement of mothers and mothers-in-law on PPFP and HTSP  
Development of PPFP IEC materials to spark discussion between husband and wife | Discuss together with your husband/wife whether to have another child and if so, the ideal period of time to wait before starting the next pregnancy.  
Go together to a FP provider (at health facility, or community-based distributor) for FP counseling.  
If you desire to have another child, discuss together the benefits of waiting at least two years after the birth before the next pregnancy, for the health of mother and baby.  
If you do not desire to have another child, discuss with your husband/wife options for limiting future pregnancies.  
As you discuss your reproductive intentions with your husband/wife, consider resources/savings involved. |
| 1a. If couple wants to have another child, they discuss benefits of waiting at least two years after a birth before the next pregnancy. |  |
| 1b. If the couple does not want to have another child, they consider options to limit future pregnancies. |  |
| **2. HEALTHY SPACING OF PREGNANCY**
  - Women/couples wait at least two years after a live birth or six months after miscarriage or abortion before starting another pregnancy, if desired. | Partner opposition (real or perceived)  
Social norms  
Lack of knowledge about risks of short birth intervals and benefits of spacing  
Method-related concerns or service accessibility challenges preventing uptake, or influencing discontinuation | Ensure health workers routinely counsel on benefits of healthy spacing of pregnancies  
Community-level education activities on PPFP and healthy spacing of pregnancies  
Ensure follow-up of continuing FP users and provide support for continued use | Waiting at least two years allows your baby to grow strong and healthy. It allows your body to recover after delivery. A mother’s health is important for the family’s well-being.  
Spacing births allows you to breastfeed your baby for two or more years. Waiting at least two years lowers chances of the next baby being born too soon/too small.  
Spacing your births allows couples to save money and resources.  
For adolescents: FP can help you finish schooling without worrying about another pregnancy too soon. |
<p>| 2a. Woman/couple uses a modern FP method continuously for at least two years after the last birth before trying to become pregnant again. |  |</p>
<table>
<thead>
<tr>
<th><strong>PPFP Behavior</strong></th>
<th><strong>Potential Barriers</strong></th>
<th><strong>Illustrative Activities</strong></th>
<th><strong>Key Information for Clients (to be adapted into context-specific messages)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. IMMEDIATE and EXCLUSIVE BREASTFEEDING:</strong></td>
<td>Lack of awareness of health benefits of colostrum</td>
<td>Ensure health workers are adequately trained on breastfeeding guidance and LAM criteria</td>
<td>Put baby on the breast immediately after birth (including drinking colostrum). Feed baby breast milk on demand, day and night. Continue to breastfeed even when you or your baby is sick. Your breast milk has all of the nutrients and water your baby needs to grow and be healthy for the first six months. Do not give the baby any foods or other liquids (not even water) before six months. Increase frequency of breastfeeding when the baby is hungrier than usual. When you feed your young baby &lt;6 months only breast milk, and you have no menses you are using an FP method called LAM. After six months, the baby should begin to take other foods and liquids while continuing to breastfeed. Discuss with your health worker which foods are best to introduce first. If using LAM, transition to another modern method of FP before introducing complementary foods (see 6 below). [For additional guidance on breastfeeding, see: the Essential Nutrition Actions Framework: <a href="http://www.coregroup.org/storage/Nutrition/ENA/Booklet_of_Key_ENA_Messages_complete_for_web.pdf">http://www.coregroup.org/storage/Nutrition/ENA/Booklet_of_Key_ENA_Messages_complete_for_web.pdf</a>.]</td>
</tr>
<tr>
<td>− Women breastfeed immediately after delivery and exclusively for six months</td>
<td>Belief that breast milk is not sufficient for the baby, especially during growth spurts</td>
<td>Health workers discuss breastfeeding with woman/couple during ANC, postnatal visits and CHW home visits</td>
<td></td>
</tr>
<tr>
<td>3a. Woman/caregiver does not feed the baby any other liquids, water, or foods for the first six months</td>
<td>Does not know timing of when to introduce other liquids, food</td>
<td>Breastfeeding support groups and champions (see Practice 7 below)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working outside the home makes breastfeeding difficult</td>
<td>Group sessions for family and mothers-in-law to discuss breastfeeding benefits and recommendations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Believes baby needs water in addition to the breast milk in order to stay hydrated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pressure from partner/mothers-in-law/other family members to feed other liquids and foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. SEEK PPFP DURING HEALTH CONTACTS:</strong></td>
<td>Lack of access to quality PPFP services; providers don’t discuss PPFP needs</td>
<td>Train providers on PPFP</td>
<td>There are many FP methods to choose from that will not decrease your breast milk or harm your baby. Visit a health provider to discuss which method may be best for you. Discuss FP options with your health worker BEFORE you are at risk of pregnancy. Discuss FP with the health provider during antenatal and postpartum visits, or with your CHW.</td>
</tr>
<tr>
<td>− Women/couples discuss PPFP options suitable to fertility desires, breastfeeding status and timing postpartum with a health worker during antenatal, birth, and postnatal health contacts</td>
<td>Lack of knowledge about return to fecundity and pregnancy risk after delivery</td>
<td>Provide community-based PPFP (especially in hard-to-reach areas)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of knowledge that there are many FP methods that lactating women can safely use</td>
<td>Conduct PPFP demand generation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide convenient services without long wait times</td>
<td></td>
</tr>
</tbody>
</table>
### 5. KNOW PREGNANCY RISK, INITIATE PPFP USE:

- Women/couples use an FP method before they are at risk of pregnancy. Couples who do not want another pregnancy consider options for limiting future pregnancies.

<table>
<thead>
<tr>
<th>Potential Barriers</th>
<th>Illustrative Activities</th>
<th>Key Information for Clients (to be adapted into context-specific messages)</th>
</tr>
</thead>
</table>
| Knowledge of return to fecundity, pregnancy risk, FP options | Conduct health education through CHWs and community groups to raise awareness about pregnancy risk after delivery and importance of timely FP uptake | Use a modern FP method before you are at risk of pregnancy:  
  - Before 3 weeks after a live birth if not breastfeeding  
  - Before 5 weeks after a live birth if partially breastfeeding  
  - Before 6 months after a live birth if exclusively breastfeeding (or sooner if menses return)  
  - By 10 days after an abortion or miscarriage |
| Method of choice not available | Train FP providers to offer clear and appropriate PPFP counseling | After these times, do not wait until menses return before starting an FP method. |
| Method-related concerns (i.e., side effects of PPIUDs) | Provide PPFP counseling and contraceptives through CHWs (especially for hard-to-reach populations) | Ovulation may occur before menses return. Once your menses return, you have already been at risk. Do not wait for menses to return to start using FP or transition from LAM to another method. |
| Social norms around PPFP | Lack of knowledge about return to fecundity and pregnancy risk after delivery | Regardless of which FP method you select, breastfeeding has benefits for mother and baby. Continue breastfeeding even if/when you are no longer using LAM. |
| Lack of knowledge about return to fecundity and pregnancy risk after delivery | Knowledge of return to fecundity, pregnancy risk, FP options |  
|  

### 6. LAM + TRANSITION:

- Women who use LAM breastfeed exclusively for up to six months as long as menstruation has not returned, and then transition to another modern method once their child reaches six months or sooner if they introduce other foods/liquids

<table>
<thead>
<tr>
<th>Potential Barriers</th>
<th>Illustrative Activities</th>
<th>Key Information for Clients (to be adapted into context-specific messages)</th>
</tr>
</thead>
</table>
| Knowledge about LAM, and when to transition | Ensure health workers know LAM criteria, routinely counsel antenatal and postpartum women on LAM + cues to transition | LAM is a natural FP method that can help space your births. It can be practiced for up to six months after delivery. In order to use LAM, there are three conditions that must be met:  
  - You exclusively breastfeed (no other foods, liquids, water)  
  - Your baby is less than six months old  
  - Your menstruation has not returned since the baby was born |
| Barriers to EBF | Incorporate LAM + transition within breastfeeding support groups, identify LAM champions | Do not wait for menses to return to start using an FP method, given that pregnancy is possible before menses appears. |
| Believes LAM is not effective; believes that women are protected against pregnancy as long as they breastfeed (even beyond six months); believes that women cannot become pregnant without menses return | Develop IEC materials outlining the LAM criteria and cues to transition | LAM is very effective as long as the three conditions are met, but if any conditions are broken before you can switch methods, use a backup method (e.g., condoms or EC) to stay protected. Visit an FP provider soon for another method. |
| Access to EC and/or condoms to use as a backup method | Provide condoms and EC to women using LAM | After transitioning to another method, initiate complementary foods at around six months and continue to breastfeeding for two years. |

### 6a. Women who choose to use LAM, use condoms and/or emergency contraception (EC) in case any of the criteria expire before they are able to obtain another method.
<table>
<thead>
<tr>
<th>PPFP Behavior</th>
<th>Potential Barriers</th>
<th>Illustrative Activities</th>
<th>Key Information for Clients (to be adapted into context-specific messages)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. PPFP CHAMPIONS:</strong></td>
<td>Cue to action</td>
<td>Identify PPFP/LAM champions within the community and form support groups</td>
<td>You can help encourage other parents and infants in your community to be healthy and grow well by encouraging them to use a FP method and telling them about your experiences using a FP method after giving birth.</td>
</tr>
<tr>
<td>– Champions discuss the benefits of healthy spacing of pregnancy, PPFP, and LAM with others in the community</td>
<td>Perceived benefits/motivation</td>
<td>Identify policymakers who can serve as PPFP/LAM advocates</td>
<td></td>
</tr>
<tr>
<td>7a. Woman/husband/mother-in-law considers forming or joining a PPFP/breastfeeding support group</td>
<td></td>
<td>Encourage PPFP/LAM users to share positive experiences with sisters, friends, neighbors, others</td>
<td></td>
</tr>
</tbody>
</table>
SBCC for PPFP Case Studies

This section highlights several of MCHIP’s SBCC for PPFP program activities. Each case study highlights formative assessment findings, the ways in which formative assessment findings informed the program design, a description of the activity/messages/materials used, and the program learning that emerged.

CASE STUDY 1: FP/IMMUNIZATION IN LIBERIA

The 2007 DHS in Liberia indicated a substantial unmet need for FP using modern contraceptive methods. According to a re-analysis of the 2007 DHS data conducted by MCHIP, less than 10% of women 6–12 months postpartum use any type of modern contraception. This same time period postpartum also overlaps with the schedule for routine infant immunization. Vaccination-related contacts with the health system during the infant’s first year of life offer a promising opportunity to also address women’s FP needs during the same period.

For this reason, MCHIP and the Ministry of Health and Social Welfare (MOHSW) designed an approach to integrate the delivery of FP and routine infant immunization services on a pilot basis from March to November 2012. Prior to initiating implementation, MCHIP conducted a formative assessment, including in-depth interviews with vaccinators and FP providers, and FGDs with postpartum women and male partners. Findings from the assessment revealed that critical barriers to postpartum contraceptive uptake included the widespread beliefs that women should not resume sexual activity until the baby walks and that contraceptives can affect the breast milk and harm the child. Women expressed a concern that they would be stigmatized by other people in the community if they were seen going for FP services while their infants were still young.

The approach designed by MCHIP and the MOHSW involved vaccinators providing a few short, targeted FP and immunization messages and same-day FP referrals to mothers bringing their infants to the health facility for routine immunization. The emphasis of the approach was co-located provision of same-day services, with the vaccinators serving as the critical referral link between points of service delivery.

This model involved the following key elements:

- During routine infant immunization sessions, at the completion of each immunization visit, vaccinators used a simple job aid to share brief, targeted FP and immunization messages one on one (not through group health talks) with mothers and refer them to the co-located FP room for more in-depth FP counseling and services. The job aid included messages that FP is safe and healthy for women with young babies and that women can indeed use FP before their baby walks (and that other women with young babies in their community like them are also...
going for FP). Interactions between the vaccinator and the client were protected by privacy screens to prevent women from feeling stigmatized for accepting FP referrals.

- Women who were interested in seeking FP services on the same day were given a referral card and were directed to the FP room by the vaccinator.
- Women who were not interested in seeking FP on the same day were given a leaflet with information about the benefits of FP for the health of the mother, father, and infant, and were encouraged to discuss FP with their partners, other family members, and/or friends and return to the facility soon for FP.
- FP providers collected referral card from those women referred from immunization services and documented the referrals in their FP ledgers.
- Posters emphasizing the message that “family planning is good for baby ma” were placed throughout the clinic, including at the immunization station and FP room. As part of the steps listed on the job aid, the vaccinator pointed out the poster to mothers. Posters also help to guide referred clients from the vaccination station to the FP room.
- Immunization services at fixed facilities (as opposed to outreach services) were identified as the primary integration platform, given that in Liberia, fixed facility services cover a greater proportion of infants and service provision tends to be more stable and consistent. Fixed facilities also permit a greater degree of privacy—which was especially important because of the sensitivity around contraceptive use by mothers of young infants.

A final assessment of the approach, conducted after nine months of implementation, revealed large increases in the number of new contraceptive users at the facilities in both counties. When comparing the intervention period (March–November 2012) with the same period in 2011, the number of new contraceptive users at participating facilities increased by 90% in Lofa County and by 73% in Bong County. The final report for this initiative can be found here: http://www.k4health.org/toolkits/family-planning-immunization-integration/liberia-epifp-final-assessment-report.

CASE STUDY 2: MATERNAL, INFANT, AND YOUNG CHILD NUTRITION-FP IN KENYA

In Bondo District of Kenya, MCHIP launched an initiative to integrate PPFP with maternal, infant, and young child nutrition (MIYCN) services. In Bondo District, contraceptive prevalence and infant nutrition indicators fall well below the national average. Prior to designing the program activities, MCHIP conducted an initial advocacy meeting with key representative from the Ministry of Health and Bondo District to highlight the rationale for integrating FP and MIYCN services. For example, MIYCN and FP have critical linkages through the promotion of EBF, LAM, and timely transition to another modern contraceptive method, the relationship between introduction of complementary foods and return to fecundity, and the links between short birth intervals and childhood stunting and underweight.

MCHIP and local stakeholders then conducted a formative assessment, including interviews with service providers and FGDs with postpartum women, their husbands, and other influential
community members. The assessment revealed the following barriers to postpartum contraceptive use:

- Lack of knowledge among service providers and postpartum women about LAM and cues to transition to another modern method
- A widespread belief among postpartum women and family members that breastfeeding alone does not provide sufficient nutrients for the infant, especially if the mother herself is not able to eat a nutrient-rich diet
- Lack of knowledge about return to fecundity and pregnancy risk among postpartum women
- Perceived side effects of using contraceptives for postpartum women

MCHIP met with stakeholders to reflect on assessment findings and design strategic activities, messages, and materials. The program that was developed incorporated activities at both the community and facility levels. At the health facility level, a “One Stop Shop” model was established where both FP and nutrition services were consistently provided to women during all antenatal, intrapartum, postnatal care, well-child, and FP counseling visits. Job aids, brochures, and posters were designed to reinforce information shared by service providers; all were pre-tested in Bondo prior to finalization. At the community level, PPFP and nutrition messages were incorporated in routine community outreach activities, such as CHW home visits, community dialogue sessions, mother support groups, and health action days. A counseling guide was developed to support CHW counseling efforts. Messages shared in both community and facility activities reinforced the idea that breast milk provides the best nutrients for the baby, even during the “hungry season.” Messages also addressed pregnancy risk after delivery, outlined the LAM criteria and cues to transition, and highlighted the benefits of practicing LAM for the mother and the infant. Materials also addressed the health benefits for the child when the mother uses FP and adequately spaces her births.

Process assessments revealed challenges with insufficient contraceptive supply at health facilities, which was later addressed through advocacy with district supply chain representatives. Strategies to further engage men are also being explored, given that women reported that partner opposition posed a continuing challenge to their use of PPFP.

### CASE STUDY 3: HEALTHY FERTILITY STUDY IN BANGLADESH

The Healthy Fertility Study (HFS), conducted in eight unions of Sylhet Division in northeastern Bangladesh, was funded by USAID. The study began in 2007 as a partnership of the Bangladesh Ministry of Health and Family Welfare, the Bangladeshi nongovernmental organization Shimantik, the Center for Data Processing and Analysis, the Johns Hopkins Bloomberg School of Public Health, and the USAID-funded ACCESS-FP project, the last of which transitioned to MCHIP in December 2010.

Sylhet Division has the highest rates of maternal and newborn mortality and the lowest rates of contraceptive use in Bangladesh. The HFS examined the effect of integrating PPFP within a community-based maternal and newborn health (MNH) program. The HFS behavior change strategy was designed to promote recommended MNH and FP practices and build an enabling environment and social support for MNH and FP to improve health outcomes. Key HFS activities included antenatal and postpartum home visits conducted by CHWs, community mobilization sessions, engagement of local champions, and advocacy through ward-level meetings.

Within the HFS, female CHWs counseled women on PPFP and provide contraceptive methods to women during antenatal and postpartum household visits. Community mobilizers also held
community meetings with women, husbands, mothers and mothers-in-law, and other family and community members to discuss return to fecundity, HTSP, and LAM, and the transition to other modern FP methods.

Critical components of the HFS behavior change communication (BCC) and community mobilization approach were counseling and discussion on postpartum return to fecundity. HFS activities used strategic, field-tested messages and materials informed by formative assessment. To inform program design and implementation, HFS conducted several assessments to assess knowledge, perceptions, and current practices, along with enablers for and barriers to recommended FP behaviors. For example, a barrier analysis found that significantly more women who successfully transitioned from LAM to another modern FP method could recall the criteria for LAM than nontransitioners; more of the successful transitioners also knew to switch to another modern FP method as soon as LAM ends. Findings from this analysis were used to inform the design and refinement of HFS messages and materials, including the development of a leaflet on return to fecundity and LAM.

The leaflet included “Asma’s story” and an image on one side, with critical messages about return to fecundity on the reverse side. The leaflet was used during postpartum home visits and community mobilization activities and to guide discussions about postpartum return to fecundity. Messages in the leaflet were designed to address a recognized gap in knowledge and acceptance among the target populations about timing of return to fecundity, pregnancy risk, and the importance of timely transition from LAM to other modern FP methods.

Asma’s story tells of how one woman incorrectly assessed her risk of pregnancy to be minimal during the months before her menses returned. Asma says that she will wait until her menses returns before starting a modern FP method, but then becomes pregnant. She learns the lesson that women can indeed become pregnant even before menses return, and that it is important to start using an FP method after delivery for healthy spacing of pregnancy. Stories like Asma’s seemed to resonate with women and their families because the stories may be consistent with women’s personal experiences or those of other women they know. These stories can also help to generate discussion about what may otherwise be seen as sensitive topics. The leaflet was used in all four HFS intervention unions in Sylhet. Findings from an assessment of Asma’s story indicate that using a fictional story offers a promising approach for motivating shifts along the behavior change continuum toward use of a modern contraceptive method.

An initiative called “LAM Ambassadors” was also designed, building on the mother-to-mother model widely used in the promotion of breastfeeding, to address gaps in knowledge about LAM. LAM Ambassadors are influential community members who have successfully practiced LAM and who commit to counseling others in their household or neighborhood about it. LAM Ambassadors are responsible for counseling friends and neighbors about the importance of LAM, and building support for the practice among other influential members of the community. Findings from the HFS indicate that integrating PPFP with the MNH platform led to a statistically significant increase in postpartum contraceptive uptake and duration of EBF.
Additional Resources

Visit the corresponding e-Learning course on SBCC for PPFP: http://reprolineplus.org/SBCC-PPFP-course

General SBCC Resources:
- C-Change SBCC Modules
- Designing for Behavior Change Curriculum (2008)
- A Field Guide to Designing a Health Communication Strategy
- Writing a Communication Strategy for Development Programs
- SBCC Strategy Template
- SBCC for Frontline Health Workers: Facilitator’s Guide
- Multi-step Process and Tools for SBCC Capacity Strengthening
- INFO Reports: Tools for Behavior Change Communication
- MAMA Mobile Messages for Maternal, Newborn, and Child Health
- Springboard for Health Communication
- The Communication Initiative
- Hesperian Images
- Photoshare

General PPFP Resources:
- Postpartum Family Planning Toolkit
- Postpartum Family Planning Community of Practice
- Programming Strategies for Postpartum Family Planning
- Maternal, Infant and Young Child Nutrition (MIYCN) and FP Integration Toolkit
- Family Planning and Immunization Integration Toolkit
- PPFP Learning Resource Package for Community Health Workers
- PPFP BCC and Demand Generation Online Discussion Forum Report
- PPFP Annotated Bibliography
- PPFP Country Profiles from Re-analysis of DHS Data
- PPFP Indicators
- PPIUD Learning Resource Package
- PPFP Course on the Global Health e-Learning Gateway

Formative Assessment Resources:
- LAM Barrier Analysis: Bangladesh
- LAM Barrier Analysis: Uganda and Guinea
- Kenya MIYCN-FP Formative Assessment Report
- Liberia FP-Immunization Formative Assessment Report
- Trials of Improved Practices Briefer
- Social Networks’ Influence on Family Planning: Mali Report
- Knowledge, Practices, and Coverage Survey Resources

SBCC for PPFP Activities and Materials:
- Bangladesh Healthy Fertility Study: BCC And Community Mobilization Briefer
- Bangladesh Healthy Fertility Study: LAM Ambassadors Briefer
Bangladesh Healthy Fertility Study: SBCC Materials
Bangladesh Healthy Fertility Study: Asma’s Story Assessment Article
Kenya MIYCN-FP Integration Materials
Liberia: FP & Immunization Integration Job Aid, Brochure, Poster
Liberia: Article on Engaging Religious Groups to promote FP
Egypt SMART Project SBCC Materials
Nigeria: Family Planning Flipchart
Afghanistan: Family Planning Flipchart
India: Family Planning Flipchart
PPIUD TV Advertisement
Global: LAM Client Education Card

[Additional materials are also available on the PPFP Toolkit]