



DOH

Family Planning Behavior Change Communication Strategy

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Acronyms

BCC	Behavior Change Communication
BHW	Barangay Health Worker
CA	Cooperating Agency
CHD	Centers for Health Development
CHT	Community Health Team
CPR	Contraceptive Prevalence Rate
DOH	Department of Health
FGD	Focus Group Discussion
FP	Family Planning
FPS	Family Planning Survey
HE	Health Events
HPC	Health Promotion Communication
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information, Education, Communication
IPC	Interpersonal Communication
IPC/C	Interpersonal Communication and Counseling
LCE	Local Chief Executive
LGU	Local Government Unit
LRA	Local Replicating Agency
MNCHN	Maternal, Newborn, and Child Health and Nutrition
NDHS	National Demographic and Health Survey
NGO	Non-governmental Organization
PHO	Provincial Health Officers
TFR	Total Fertility Rate
USAID	United States Agency for International Development
WHT	Women's Health Team
YAFSS	Young Adult Fertility and Sexuality Survey

I. BACKGROUND

PURPOSE OF DOCUMENT

The purpose of this Behavior Change Communication (BCC) Strategy is to guide the Department of Health (DOH) on the effective use of strategic health communication for family planning (FP). Fertility and contraceptive use rates in the country have remained largely unchanged for the past five years. A large proportion of births are either mistimed or unwanted. Unmet need for family planning is still high. While the Philippines has implemented numerous FP health promotion activities over the last decades, through mass media, print, advocacy and interpersonal communication, many efforts have been sporadic and small-scale rather than part of a unified, national and comprehensive program. In addition, programs have tended to focus mainly on women and promoted the health benefits of FP for women and children. These approaches have been important and essential but have also resulted in lost opportunities to involve men in FP, target young people, and address other values that may actually drive contraceptive use.

This document outlines how DOH envisions using *strategic* communication to enhance family planning and maintain behavior change among targeted market segments in the Philippines. The strategy builds on the understanding that encouraging individuals or couples to use family planning is a process, involving distinct audiences that need different messages, market positioning and approaches. Information alone is not enough to bring about behavior change among any audience. Instead, DOH's strategy is based on a multi-level, synchronized, holistic marketing approach to family planning. The approach is unique in that it focuses on increasing modern contraceptive use through: 1) *demand generation through market segmentation* – i.e., increasing knowledge and skill, forming positive attitudes towards contraceptive use and birth spacing, and understanding the benefits of family planning among 3 client markets segments; 2) *social marketing* – i.e., re-packaging and selling the concept of family planning as a life style that contributes to better quality of life for all members of the family; unified branding to integrate FP across different programmatic interventions and reinforce FP messages in the clients' minds and 3) *service marketing* – i.e., improving quality of FP services by building capacity of FP providers, monitoring and supervising implementation of service quality, promoting model providers, and creating a socio-political environment supportive of FP.

The document results from a review of existing research on client and provider FP behaviors in the Philippines, an analysis of current and past FP communication initiatives in the country, focus group interviews, and careful communication planning. The development of this document is also based on technical assistance provided by the

Health Promotion and Communication (HealthPRO) Project / USAID to DOH in support of the national agenda in MNCHN and FP.

This document is primarily for DOH which provides a map of FP BCC strategies to implement from the client, to the provider, local, and national levels to ensure a targeted, evidence-based, and coordinated response.

II. SITUATIONAL ANALYSIS

A. FAMILY PLANNING CHALLENGES

Many women are having more children than they want – especially the poor

Currently, the total number of children a Filipino woman has during her reproductive years – or the total fertility rate (TFR) – is one child higher than the desired number (TFR 3.3 vs. 2.4). For the poorest women, the number of children a woman has is about two children higher than desired (TFR 5.2 vs. total wanted fertility rate 3.3) (NDHS, 2008).

While women in rural areas have on average one more child than in urban areas (TFR 3.8 vs. 2.8), they all are having more children than they want (Total wanted fertility rate rural 2.7; urban 2.1). Regional differences in the TFRs are substantial, with some regions having higher gaps between actual fertility rates and wanted fertility rates than others (NDHS, 2008). Even though the TFR in the country has declined considerably in the last 30 years, the Philippines still has the second to highest TFR in Southeast Asia (UNFPA, 2008).

A large proportion of married women, especially those with 2+ children want no more children, yet contraceptive use is low

More than half (54%) of married women in the Philippines want no more children. The proportion of women who want no more children increases with the number of living children – from 21% among women with one child, to 62% among women with 2 children and 81% to women with 3 children (NDHS, 2008).

Contraceptive use is low and has remained fairly stagnant over the last five years. Only one out of two (51%) married women is using a family planning method, with only one out of three (34%) using a modern method. For all women – those who are married and unmarried – only one in three (33%) women currently use any method of contraception, with only one in five (22%) using a modern method (NDHS, 2008).

There are glaring disparities in contraceptive use among regions. Also, contraceptive use tends to be lower among those married women who are younger, poorer, those with fewer years of education, and/or those living in rural and/or in underserved regions (NDHS,

2008). These statistics fall short of the Department of Health's target of an 80% modern contraceptive prevalence rate (CPR) by 2015 as well as many couple's own desires to limit their family size (DOH, 2009).

The most widely used method is the pill (16%), followed by withdrawal (10%), female sterilization (9%), and rhythm (6%) (NDHS, 2008). Forty-two percent (42%) of married women not currently using contraception intend to do so in the future (NDHS, 2008).

Unmet need for family planning has increased and is highest among adolescents

Almost one in four (22%) women in the Philippines have an unmet need for family planning and unmet need has increased over the last five years (NDHS, 2008). Unmet need for family planning is defined as the percentage of married women who either want to stop having children or want to wait for their next birth but are not using any method of family planning. Adolescents ages 15-19 have the highest unmet need for family planning (36%). Also, the percentage of married women whose demands for family planning are satisfied are much lower among 15-19 year olds – suggesting that family planning programs may not be serving them as well as older women (NDHS, 2008).

Unmet need is slightly higher in rural areas than in urban areas (24% vs. 21%), differs among regions, and is higher among lower educational levels and poorer women (NDHS, 2008).

Many mistimed and unwanted pregnancies

One of the immediate consequences of unmet need for family planning are unintended pregnancies. In the Philippines, over 1 in 3 pregnancies are either mistimed or unwanted (20% are mistimed and 16% unwanted) (NDHS, 2008).

Many women obtain an abortion when they discover an unplanned pregnancy. Estimates show that about one in five (18%) pregnancies in the Philippines end up in illegal abortions, mostly in unsafe conditions that can lead to maternal deaths (Commission on Population Philippines, 2009).

Short birth intervals, especially among 15-19 year olds

If a woman becomes pregnant too soon after a previous birth or miscarriage (i.e., within 24 months), she and her newborn are at higher risk of health complications or even death. If the pregnant woman is very young, (i.e. the mother is younger than 18), both the mother and her baby are at increased risk of health complications (ESD, 2010). Currently, 30% of births in the Philippines are spaced less than two years apart. Younger women, especially those ages 15-19 years, have shorter birth intervals than older women (NDHS, 2008).

Better quality of life motivates couples to practice family planning

Desire to have a better quality of life is the predominant motivation among couples to practice family planning. Couples who are convinced on the importance of family planning expressed their willingness to spend for contraceptives than to have another child. Benefits of family planning such as “for the health of the mother” and “for the well-being of the whole family” are also mentioned (HealthPRO, 2009). PSP-One research shows that the underlying motivations behind non-users wanting to practice family planning were either concerns about financially supporting a family or the felt need to pursue an education or a career (PSP-One, 2009).

B. CAUSES OF LOW AND STAGNANT CONTRACEPTIVE USE

Misinformation, health concerns, and fear of side effects

Knowledge about contraceptive methods is generally widespread. However, one out of two married women not currently using any family planning method do not intend to do so because of health concerns and fear of side effects (NDHS, 2008) – indicating a lot of misperceptions about family planning. Similarly, in focus group discussions (FGD) conducted by HealthPRO in 12 Philippine provinces, fear of side effects and health concerns were cited as the main reason for couples not to practice family planning or to discontinue its use (HealthPRO, 2009). Research conducted by PSP-One found that non-users of contraception had strong opinions about the efficacy and benefits, as well as disadvantages, of various methods (PSP-One, 2009).

Intrapersonal communication (IPC) is a key method to clear up misconceptions and for convincing women and men about the advantages of FP. During focus group discussions conducted by HealthPRO/USAID, a majority of the couples and individual said that they preferred interactive type of information dissemination on family planning. Specifically, they prefer home visits and small group sessions because then they can easily raise specific issues and concerns about FP and can get immediate responses from health service providers and community health volunteers (HealthPRO, 2009).

Lost opportunities to involve men in FP programs

While there have been increased efforts in the last decade to include men in FP programs, FP BCC in the Philippines has generally focused on women. Filipino men, for the most part, have favorable attitudes to FP (Clark et al., 2007). Husbands’ opposition to family planning accounts for only 3% of non-use. However, use of modern methods of male contraceptives is very low, with only 11% of women reporting use of male condoms and 0.1% reporting male sterilization (NDHS, 2008).

Small family sizes may not be the norm for all husbands. Overall, women in the Philippines want a family size of 2.4 children. While the majority of married women (71%) say that their husbands/partners want the same number of children as they do, one in five (20%) report that their husbands want more children than themselves. These numbers differ widely by region, with 45% of women in ARMM reporting that their husbands want more children than they do and only 16% reporting so in the National Capital Region (NDHS, 2008).

Economic necessity appears to be the force behind men's interest in FP. Yet, FP is largely promoted for its health benefits for women and children. It is important that future FP BCC communication focuses on the self-interest of men as providers for the family, stressing the financial benefits of FP and small family sizes (Clark et al., 2007).

There have been promising approaches to reach out to men including working with champions and community influentials, use of well-known acceptors of male sterilization, male organizations and leaders, and quality patient services (Clark et al., 2007). These approaches need to be expanded.

Lost opportunities to target young people in FP programs

Young people are a group especially in need of family planning information and services. Young people ages 15-24 comprise one-fifth of the population of the Philippines (State of the Philippine Population, 2003). A large number of these are either married (27% of 20-24 year olds) or are living in a rapidly changing environment with a rising trend in pre-marital sex (NDHS, 2008; State of the Philippine Population, 2003). Data from the *Young Adult Fertility and Sexuality Survey* (YAFSS III) shows that 23% of young people have had pre-marital sex. Of these, almost all (94%) said they were unwilling or unprepared to become parents. Most Filipino youth did not use any contraception during their first or last sexual encounter (75% first, 79% last) (State of the Philippine Population, 2003).

Among married women, 15-19 year olds are the age group with the lowest rates of contraceptive use, highest unmet need for family planning, and shortest birth intervals (NDHS, 2008).

While there are some sound programs in the Philippines focused on youth and their reproductive health needs, including family planning, many youth have limited access to reproductive health services, or are unwilling to use them even when they are available. In addition, health workers are primarily trained in meeting the special needs of youth in terms of confidentiality, privacy, cost and accessibility – and rarely the needs of adolescents. Most parents and guardians do not know how to communicate openly about sexuality with young people (State of the Philippine Population, 2003).

Quality of family planning services lacking: lack of IPC/C skills and service provider biases

Health providers – both in the public and private sectors – may not be providing complete information about family planning. According to the 2008 NDHS, one-third of current modern contraceptive users were not informed about possible side effects or problems of the method they are using (32%); about what to do if they experienced side effects (33%); and of other methods that could be used (37%). In general, the public sector was more likely to inform clients about contraceptive methods, choices, and side effects than the private sector. For the public sector, provision of information was particularly lower in government hospitals; for the private sector in pharmacies (NDHS, 2008). Providers' beliefs, religious affiliation, bias for a certain method and level of comfort with sexuality issues may also affect the delivery of FP services. Mothers participating in focus group discussions described how some providers simply asked them to subscribe to a particular method, such as natural family planning (NFP), instead of giving them information about the full menu of FP methods. Some providers rarely initiate discussion about issues pertaining to sexuality because they either lack skills to do so or are uncomfortable to discuss such concerns (Felix, 2004). Providers may be particularly reluctant to assist adolescents with education on preventive measures, thinking it will encourage promiscuity and unacceptable sexual behavior (Osteria et al., 2004).

This highlights the need to strengthen the quality of FP services, including updated information, enhancing intrapersonal communication and counseling (IPC/C) skills in FP among service providers and training them to be sensitive to the needs of younger populations, promoting model providers, and monitoring and supervising implementation of service quality.

Missed opportunities – information about FP not integrated sufficiently into other health services or other modes of communication

While health care providers are an important source of information on family planning, many people do not visit health care providers unless they are very ill, thus limiting the opportunity for providers to reach and advise couples about contraception (PSP-One, 2009). Unwillingness to go to the nearest health center for FP services or information was also cited in focus groups (HealthPRO, 2009). However, while many women who are not pregnant may not have frequent contact with health service providers, pregnant women and mothers do – creating a key opportunity for providing FP information. The majority of women (91%) see a health provider during at least once for antenatal care (NDHS, 2008). Many also see a health care provider to get their child immunized (80% of children in the Philippines are fully immunized according to the NDHS, 2008). Women also see their health service providers during postpartum care, post-abortion care,

family planning services, HIV/AIDS services, cervical cancer screening program, youth services, and community outreach services.

The most common source of contraceptive methods in the Philippines is from the pharmacy, which supply about 40% of users of modern methods. However, only 1 in 2 women users of contraceptives are informed in the pharmacy about side effects (51%), what to do in case they experienced side effects (56%) and other methods that could be used (56%) (NDHS, 2008). This provides a missed opportunity to reach current users through pharmacies with more accurate information about contraceptives and referrals to health facilities.

Most FP health promotion materials in the Philippines have used either information or advocacy strategies using mass media such as radio, TV, and or print to convey their messages (Tuazon, 2009). On a more limited scale, interpersonal communication has been used. According to the 2008 NDHS, the majority of women not using contraception (83%) in the last 12 months, neither discussed family planning at home with a fieldworker or at a health facility with staff (NDHS, 2008). This creates a missed opportunity among existing health providers to inform women about contraception and provides an opportunity for other influentials (i.e. peers, community leaders, etc.) to provide FP information as well.

Public vs. private provision of FP services

Up until 2007, most contraceptive commodities were provided free of charge in government facilities. Now, the country is operating under the Contraceptive Self-Reliance (CSR) Strategy, which shifts the dependency on donated contraceptives to domestically supplied contraceptives. CSR strategies have recommended providing the public supply of family planning to the poor and encouraging those who can pay to go to the private sectors. To support LGUs in providing contraceptives, about P2 billion has been included in the national budget since 2007 (Commission on Population, 2009). Because of decentralization, however, the LGU response to procurement of family planning commodities for their constituents has varied.

Forty-six (46%) of users obtain contraceptives through public (government) facilities. Fifty-one (51%) obtain them from the private sector (NDHS, 2008). A higher percentage of poor users obtain supplies from public sector (69%). If users obtain their method from the private sector, they usually do so through pharmacies (FPS, 2006). A recent study by PSP-One showed that most non-users feel that the cost of seeing a private doctor is too high (PSP-One, 2009). HealthPRO focus groups also showed that couples who belong to the lower economic strata said that they want to use family planning but do not have the money to spend for it (HealthPRO, 2009). At the same time, however, many

consumers in the Philippines are willing to pay some amount for family planning services and commodities especially if the services are of high quality and priced appropriately (Policy Matters, 2000).

A consumer study to compare users of public and NGO FP service delivery points found that when choosing a service provider, respondents were particularly concerned about how close the facility was to their home, the cost of services, staff friendliness, privacy, anonymity, cleanliness, waiting time and length of clinic hours (Policy Matters, 2000).

One key to increased contraceptive use, therefore, is to have sufficient stock at public sector facilities, to price the commodities low enough at private sector facilities so that people can afford them, to better publicize services and their locations, and to redirect potential users who can pay to the private sector through BCC efforts and by highlighting the financial benefits of using FP. Advocating LGUs for adequate public and private sector support and investment in FP interventions is needed.

III. DOH FP BCC STRATEGY

A. OVERALL GOAL

Increase and sustain the use of modern contraceptive methods among men and women of reproductive age in the Philippines.

B. STRATEGY OBJECTIVES

Plan and implement comprehensive and integrated strategic FP BCC interventions to:

- Repackage and position family planning as an important contributing factor to better quality of life;
- Create universal access to accurate, consistent and synchronized information about family planning;
- Empower couples to seek information about family planning and utilize the available quality services;
- Generate demand for quality family planning services that are integrated and client-centered through increasing awareness, changing behaviors, and addressing health concerns;
- Conduct service marketing through providing and portraying quality FP services, and building the capacity of FP providers, promoting model providers, and monitoring and supervising implementation of service quality;
- Help build and sustain community partnerships which advocate for and create local positive norms and initiatives that support family planning; and
- Create enabling supportive environment among LGU stakeholders – Advocate for policies that remove barriers to and motivate coordinated efforts toward modern contraceptive practice improvement.

C. STRATEGIC APPROACH

Strategic Framework

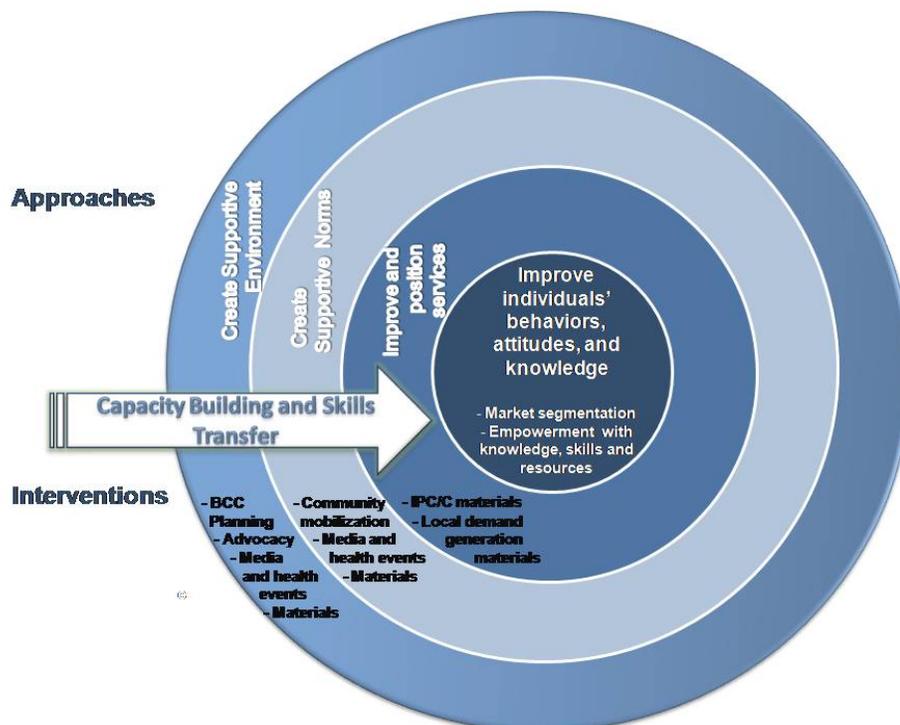
The DOH FP BCC strategy is based on the following conceptual framework. The model shows that the FP BCC interventions will impact behavior through 4 different approaches:

1. **Creating enabling environments at the regional, provincial and community levels.** This involves: increasing and channeling political will through local advocacy

- and coalition building; developing a shared vision, goals, policies, and strategies; developing unifying themes and approaches; improving the climate of public opinion around family planning related issues; and coordinating among other different relevant interventions.
2. **Creating positive supportive norms.** Use multi-stage communication and marketing interventions to establish local partnerships, community mobilization and community based marketing initiatives.
 3. **Improving quality of health service delivery.** Increase the effectiveness of client/provider interactions; increase client access to accurate, consistent and tailored information; and promote and position quality service facilities/providers in the communities.
 4. **Involving individuals.** Through proper audience segmentation; increase individuals' FP-related knowledge; change clients' and providers' attitudes towards FP, including adopting the attitude that FP contributes to enhancing individuals' quality of life; and build self-efficacy and skills in adopting the use of modern family planning methods.

Capacity building and skills transfer are the overarching strategies for achieving these approaches.

Diagram 1: The Strategic Framework



Guiding Tactics

There are a number of guiding principles that will inform and drive the design and implementation of DOH FP BCC activities. These principles will play a fundamental role in integrating program activities across different audiences – from individuals, to service providers, and stakeholders in the socio-political environment.

- Use a strategic participatory planning approach to localize and tailor FP BCC interventions to each province

DOH will use a strategic participatory planning approach at the national, regional and provincial levels to engage partners and CAs in developing robust BCC operational plans for FP. By doing so, each plan will be based on the situation, issues, and data of each province and tailored to meet the needs of each particular locality. These operational plans will be conducted on a yearly basis, through a systematic and participatory process of prioritization, ranking, and staging of activities. The participatory process will help build consensus and ownership among the different stakeholders, help address their different provincial objectives for FP, and address emerging needs.

- Coordinate relevant health-related strategies/activities so that they are mutually reinforcing

DOH will utilize appropriate venues and channels from the current MNCHN strategy to maximize dissemination of FP messages whenever appropriate and convenient. In addition, DOH will ensure that FP and FP communication is integrated into other health services (e.g., antenatal care, postnatal care, HIV and STI programs, child immunizations, etc.) whenever and wherever there are appropriate and relevant opportunities. DOH NCHP will provide the needed TA to concerned counterparts and partners, including CHDs to ensure that all communication interventions, including the advocacy and BCC components of other health related strategies, will be designed to work across and support services, and programs in the public, NGO, and private/commercial sector.

In addition, DOH will provide the needed technical assistance to national partners for the design and production of future tool kits which include job aids, promotion and communication materials for use in all sector settings.

- Coordinate across non-health sectors, including public-private partnerships

DOH's FP BCC activities will be integrated into non-health sectors working in the areas of population, education, religion, social development, military health, the environment, consumerism, business, and economic development, among others. These will include non-traditional partners in Councils, Ministries, social networks, NGOs, and the commercial sector. In particular, DOH will work to stimulate private and public sector organizations to work together to support and sustain certain BCC interventions and activities on the local level.

- Empower local community and social networks to take an active role in FP BCC

DOH will provide technical assistance to empower members of the local community and social networks (i.e. immediate influentials/community champions) with the needed information, skills and resources to take an active role in planning and disseminating FP-related health messages and maximize their impact.

Strategic Intervention

1. Market Segmentation

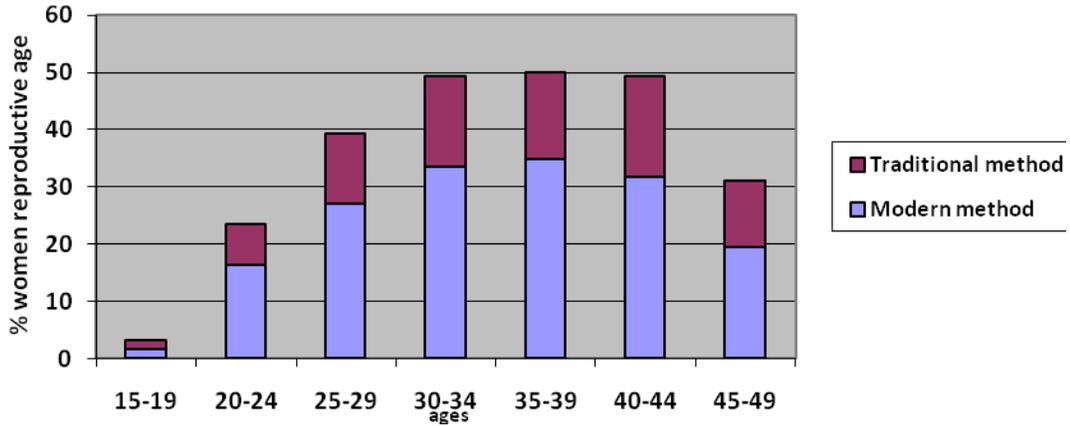
DOH will design and support information, communication programs and services to respond to the unique needs associated with 3 key reproductive stages or family planning market segments. The market segmentation was done based on the current FP situation in the country, and careful audience and program analysis – including the behaviors and needs of different FP clients/ potential clients and current program needs (see Section II). The market segments are described below.

- ***Prime the FP market:*** Programs targeted towards young people (ages 15-24) who are either married or unmarried but have no children. We refer to this audience segment FP as “initiators.”

The age group with the lowest rates of contraceptive use is 15-19 year olds. For married women, 15-19 year olds is the age group with the lowest contraceptive use, highest unmet need for family planning, and shortest birth intervals (see Figures 1 and 2). As was seen in the Situation Analysis, pre-marital sex is becoming more common, during which most young people do not use contraception. Programs for this market segment will empower young people with accurate information, improve their attitudes towards FP, provide them with information on different methods and where to go to seek family planning information and services, when they need it. This

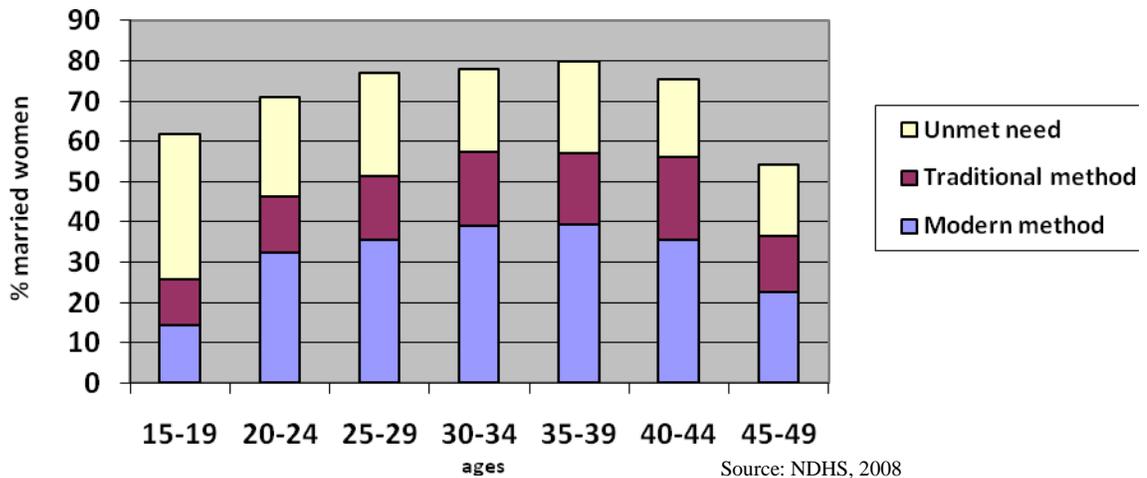
will ensure successful FP use upon entry into the FP market (i.e. when they become sexual active or upon the birth of the first child).

Figure 1: Current contraceptive use especially low among young people



Source: NDHS, 2008

Figure 2: Unmet need for FP highest among 15-19 year old married women



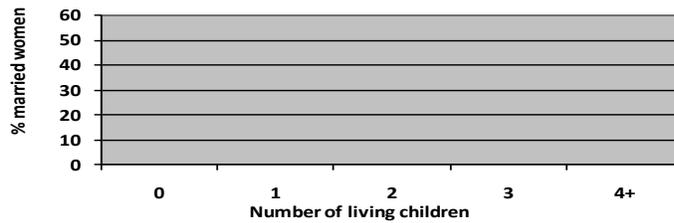
Source: NDHS, 2008

- **Capture the FP market:** Programs targeted towards young married women, men and couples with 1 child to increase their knowledge, improve attitudes towards FP, address side effects and misconceptions and increase successful use of modern contraceptives for birth-spacing. We refer to this audience segment as “spacers”.

This is the group most receptive of family planning: 22% of married women begin using contraceptives after their first child, compared to only 5% of women before

having any children, and 12% after the birth of the second child (NDHS, 2008). It is also the group where the highest percentage of non-users intend to use contraceptives in the future (see Figure 3).

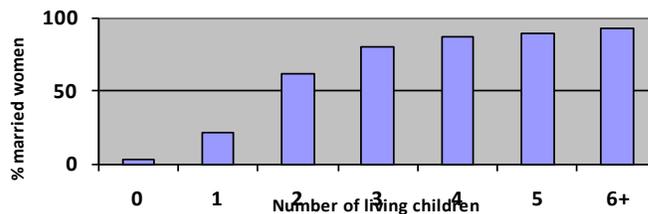
Figure 3: Percent non-users intending to use in the future



Source: NDHS, 2008

- Maintain the FP market:** Programs targeted towards married women and men with 2+ children to promote small family sizes and long-term methods of FP. We refer to this audience segment as “limiters”. This is the segment where the majority desires to limit childbearing (see Figure 4) but only 33-43% use a modern form of contraceptive (NDHS, 2008).

Figure 4: Percent currently married women who want no more children



Source: NDHS, 2008

2. Audience, Communication Goals, Behavioral Objectives, Communication Objectives

Table 1 outlines the specific audiences, communication goals, behavioral objectives, and communication objectives per market segment.

Table 1: Audience, Communication Goals, Behavioral Objectives, Communication Objectives per Market Segment

	Market Segments		
	Prime the FP Market : “Initiators”	Capture the FP Market: “Spacers”	Maintain the FP Market: “Limiters”
Audience: Primary	- Initiators: Adolescents (ages 15-19) and young people (ages 15-24) with 0 children living in rural and urban areas (married and unmarried)	- Spacers: Married women and men with 1 child living in rural and urban areas	- Limiters: Married women and men with 2+ children living in rural and urban areas
Secondary	- Immediate influentials - Local champions - LGU officials	- Immediate influentials - Local champions - LGU officials	- Immediate influentials - Local champions - LGU officials
Communication Goals	- Encourage healthy timing of pregnancy	- Encourage healthy birth spacing	- Promote small family sizes - Promote long-term methods of family planning
Behavioral Objectives	- Increase use of modern contraceptives by 15-24 year olds	- Increase % of currently married women with 1-2 children using any modern method of FP	- Increase % of currently married women with >2 children using any modern method of contraception

				Market Segments		
				Prime the FP Market : “Initiators”	Capture the FP Market: “Spacers”	Maintain the FP Market: “Limiters”
Communication Objectives	<ul style="list-style-type: none"> - Increase accurate in-depth knowledge about fertility, FP, and healthy timing of pregnancy - Increase numbers of young people who know where to go to seek modern contraception if needed - Improve health providers IPC/C on FP for young people 	<ul style="list-style-type: none"> - Reduce number of women citing fear of side effects as a reason for non-contraceptive use - Increase accurate in-depth knowledge about relationship of healthy birth spacing and healthy birth outcomes - Increase number of couples that discuss the use of contraception - Increase percentage of men and women endorsing the practice of FP to others - Improve health providers IPC/C on FP - Increase appropriate action for FP by LGUs and the private sector 	<ul style="list-style-type: none"> - Increase favorable attitudes towards small family size - Increase number of couples that discuss the use of contraception - Increase percentage of men and women endorsing the practice of FP to others - Improve health providers IPC/C on FP - Increase appropriate action for FP by LGUs and the private sector 			

3. Positioning

In order to develop a long-term positive identity that people associate with FP, rather than negative attitudes and beliefs, DOH will use social marketing to work with national and local levels to ensure that FP is re-packaged and positioned across all audiences as an important contributing factor to enhancing quality of life, and as part of modern life style. The role of family planning in improving quality of life (i.e. being good for the health of the family, being financially beneficial; and helping provide a bright future) was found to be a main motivator for family planning in recent research (HealthPRO, 2009; PSP-One, 2009; Clark et al., 2007) (for a review of motivators see also Section IIA).

DOH, together with its stakeholders, will design a unique label/ image to position this theme that will easily be remembered in the minds of the audience. Positioning all DOH program activities under this comprehensive theme/image will better integrate different programmatic interventions, behaviors, and stakeholders at both national and local levels.

The purpose of the comprehensive theme/image is to help ensure that all stakeholders and participants in the communication program, from the national to the local levels, understand what the central thrust of the strategy is. During message development, for example, positioning will help ensure that there is a consistent understanding across all levels of which messages are consistent with the strategy and which are not.

DOH will utilize different strategies and tactics on both the local and national levels to give a market value for the theme/image. For example, it would be a value added, if other targeted campaigns/materials or activities will include DOH's same image/theme in order to be mutually reinforcing.

4. Channels

IPC/C – IPC/C consists of awareness building and capacity building. DOH will conduct IPC/C at the LGU-level, both with individuals and with groups and in both health facility and community settings. IPC/C in groups in the community overlaps with community outreach and community mobilization. DOH will focus on improving the IPC/C skills of service providers – working at health facilities and on outreach within the LGU geographic coverage – and of volunteers who work in the community (see section on “community mobilization”).

- Improve IPC/C skills of health service providers.

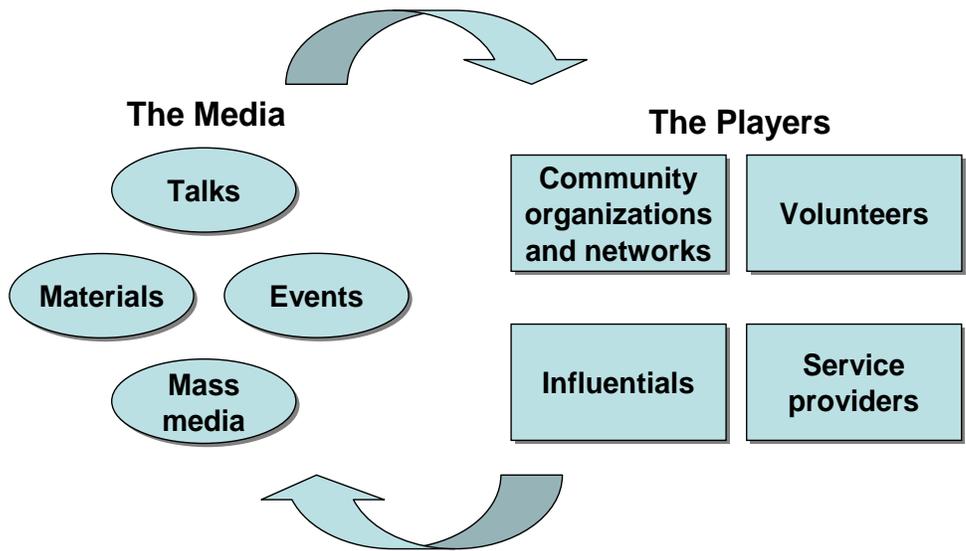
Focus group discussions showed that both men and women prefer face-to-face communication through health service providers within communities, rather than mass media (HealthPRO, 2009). PSP-One research showed that women trust health service providers for information about FP (PSP-One, 2009). Currently, health

providers – both in the public and private sectors – may not be providing complete or quality information about family planning due to a lack of skills, certain attitudes or biases (see Section IIB).

DOH will work with LGUs, Provincial Health Offices (PHOs) and CHD staff to build the capacity of service providers on IPC/C (including service providers in health facilities, health outreach workers such as WHTs/CHTs, and pharmacists) through IPC/C trainings and workshops, development of BCC materials and job aids. IPC/C will be reinforced through supervision and monitoring. DOH will ensure that appropriate IPC/C materials, training materials, and job aids will be packaged using a coherent image and theme to represent a unified message (for example “We care”). DOH will ensure that FP service providers understand that they are providing services to three distinct market segments, and that each segment may need different approaches and counseling. To do so, either existing materials will be adapted or new materials will be developed.

Community mobilization – DOH will use a combination of talks, BCC materials and health events as media for mobilizing communities around FP issues. These media will be used by service providers, community volunteers, existing organizations and networks within the community, and influentials to raise awareness and change behaviors with respect to FP:

Diagram 2: The Community Mobilizing Team and its Approaches



Messages will be chosen to focus on:

1. Raising awareness that side-effects or health concerns are *not* good reasons for non-use of contraception.
2. Encouraging couples to discuss use of contraceptives.
3. Seeking both female and male endorsement of use of FP.
4. Appropriate FP positioning for each market segment.

- Talks:

Community-based FP talks will be conducted in small groups, involving female, male and mixed audiences. Some will be part of existing community outreach from health facilities and involve primarily RHU and BHS midwives reaching out to the communities their facilities serve as well as BHWs identifying and inviting people with unmet need for FP to community FP sessions. Others will be conducted by volunteers (e.g., existing community health volunteers, satisfied clients, informal sector workers) and others will be handled by peer educators. In addition, DOH will collaborate with other private sector partners whenever it is appropriate (e.g. AlphaMed, DKT, etc.) and their community mobilizer teams to conduct community-based FP talks. Other community organizations and networks capable of providing DOH with access to large numbers of individuals as audience for its messages will include: mothers' clubs; schools; shopping mall owners; sports clubs; youth groups; major public employers like police or local government; local chapters of farmers' societies, labor unions, medical professionals' associations, trade associations, etc.

DOH will conduct community-level advocacy aimed primarily at community influentials to encourage people to visit health facilities – to seek appropriate care, treatment or additional information for FP or broader MNCHN services. The influentials will include local chief executives, religious leaders, local industry leaders and respected professionals.

- Events:

Events of two types will be held regularly to maximize reach and visibility for DOH's FP themes in the community:

- DOH will help LGUs to support events in the DOH's annual calendar, focusing in particular on FP Month in August each year. A standard menu of technical assistance describing how DOH and an LGU can work together to hold community events in FP Month is being prepared.

- In addition, DOH will encourage partner municipalities and barangays to hold mobile mini-events – e.g., in local streets, shopping malls, or existing community festivals – using mobile display and information booths or vans. The booths may be purchased by municipalities and also made available to constituent barangays; the vans may be rented at either level. Both will be staffed by volunteers – either Barangay Health Workers or the volunteers.
- Local mass media:

LGUs will be encouraged (and trained) to use local mass media, both conventional and innovative, to support their FP awareness and behavior efforts. Conventional media will include local TV, radio and newspaper placements which offer community-level reach; experiments will also be supported by DOH to see if more innovative, electronic media – e.g., internet and SMS – can have an impact by reaching new target FP audiences, particularly the younger groups in the ‘initiator’ segment.

- Materials:

Materials will be designed, tested and pilot-produced DOH (and subsequently mass-produced by LGUs) to accompany the talks and events (e.g., posters, videos) and provide handouts at both (e.g., brochures and leaflets). These and additional materials will be made available at fixed distribution points throughout the community, where they can be displayed and offered for take-away reading. Volunteers will be assigned responsibility for each location to ensure materials remain in stock and municipalities and barangays will be encouraged to fund purchase of the display stands or racks. New materials will also be custom-designed for special FP target groups – e.g. a ‘congratulations’ pack for newly-weds, to be handed out at pre-marital classes and other venues, and covering such topics as method choice and the dangers of early pregnancy; a ‘wellbeing’ pack for new mothers, addressing post-partum FP and rumors about FP-related side-effects and health problems; a ‘wait and educate’ video for use with women and men in any waiting areas in the community. For advocacy, some tailored materials will be needed (e.g., advocacy toolkits) but many of the materials developed to support more general talks and events can be used here as well.

As mentioned under the “Positioning” section all four media types in use at the community-level will be integrated by use of a common brand that will depend on its field testing by national and local counterparts – e.g., improving quality of life; or “*Kilos Kalusugan*” – roughly translated as ‘movement for health’ are illustrative examples. Unified branding will help to reinforce FP messages in the client’s mind

by drawing attention to different materials in different situations with a recognizable logo and tag-line. It will also help usefully to integrate FP with other health areas using the same brand (especially MNCHN) and thereby attract interest in messaging which can cross health areas – e.g., breastfeeding/lactational amenorrhea or nutrition/birth spacing.

Just as common branding provides communication coherence, DOH will work through development partners to evolve a single, community-level management approach to recognize and draw together into a single governance structure all the various strands of community mobilization described above. This structure will be placed at the Barangay-level and will be reconciled with the community-level approaches being developed by partners. This structure – as for example “KK Committee” or some other term based on the common brand chosen, to add coherence to a program that includes more health areas than just FP – will cover financing, program design, personnel and technical assistance aspects of community mobilization. It will be important that the Barangay Chairman, as the main local government representative at the community-level, be visibly and actively associated with the program. Other committee members can include the RHU midwife, CHTs/WHTs, BHS midwife, volunteers, TB Patrols, and/or workplace educators.

5. Activities

Table 2 outlines examples of activities, positioning, and key messages by market segment. The activities will help generate *demand for services* through increasing knowledge and awareness (e.g., about the fertile period; HTSP; benefits of FP), addressing misperceptions, and helping change behavior. The activities will also improve FP *service marketing* by building the capacity of FP providers, monitoring and supervising implementation of service quality, and promoting model providers.

Table 2: Illustrative activities, positioning, and key messages by market segment

	Illustrative Activities	Market Segments		
		Prime the FP Market “Initiators”	Capture the FP Market “Spacers”	Maintain the FP Market “Limiters”
Media/health events	- Media summit/meetings/ information kits/ mailings to key media personalities (health beat reporters, influential national and local radio broadcasters, local newspapers) to encourage and promote FP messages on their shows, articles in their newspapers etc.	✓	✓	✓
	- Brochures, posters, promotional materials (i.e. fans, caps, T-shirts)	✓	✓	✓
	- Stickers (e.g., to place on buses, jeepneys, taxis, tricycles, kiosks, toilet stalls, breastfeeding stations in malls, local gyms, spas, beauty parlors)	✓	✓	✓
	- Broadcast radio plugs	✓	✓	✓
	- Wait and educate videos in RHU health facilities; public places/forms of transport with long waits (e.g., bus terminals, buses; ferries; sari-sari stores)	✓	✓	✓
	- Information dissemination at community events, i.e. pamphlets, health booths, Sangguniang Kabataan (SK) events (i.e. youth night; LGU fiestas)	✓	✓	✓

	Illustrative Activities	Market Segments		
		Prime the FP Market “Initiators”	Capture the FP Market “Spacers”	Maintain the FP Market “Limiters”
	- Information dissemination at local DOH health events. Examples: through DOH Garantisadong Pambata (GP) initiative/GP week; FP Month, World Population Day, Population and Development Week		✓	✓
	- Text message reminders about healthy life choices	✓		
	- Print information about responsible parenthood on the back of birth certificates		✓	✓
	- Provide TA to POPCOM’s Battle of the Bands to integrate FP messages	✓		
	- Incorporate FP messages and materials into Buntis pageants		✓	✓
	- Incorporate birth-spacing messages into DOH COMBI for exclusive breastfeeding		✓	✓
	- Insert messages into/onto direct selling products (e.g., personal hygiene products for both women and men; laundry and dishwashing liquids; baby products; on back of pre-paid phone cards; on grocery bags)/ partnership with private sector firms selling products	✓	✓	✓
	- Insert messages into popular internet sites young people use	✓		
Community Mobilization/ Advocacy	- Advocacy materials about FP as part of DOH’s GP initiative		✓	✓
	- Provide TA/advocacy briefer for LGU officials on benefits of FP per market segment (collaborate with	✓	✓	✓

	Illustrative Activities	Market Segments		
		Prime the FP Market “Initiators”	Capture the FP Market “Spacers”	Maintain the FP Market “Limiters”
	different development partners (e.g., USAID, UNFPA, World Bank, etc.)			
	- TA for developing province-specific FP BCC strategies, including M&E and activities	✓	✓	✓
	- Mobilize key influential groups/people (e.g. informal workers, tricycle drivers, teachers, community leaders; satisfied users) with large constituencies among the three segments to provide key FP messages and act as spokespersons/or “champion” FP, provide testimonials (i.e. men who have undergone vasectomy)	✓	✓	✓
	- Home visits by fieldworkers to invite people with unmet need for FP to support groups		✓	✓
	- Workplace FP promotion (partner with private and public sector workplaces to provide information and materials on FP and responsible parenthood to workers through seminars, orientation for new workers, etc./ partner with other partners doing this – e.g., PRISM/USAID)	✓	✓	✓
	- Workshop with religious leaders (Christian, Muslim) to endorse practice of FP	✓	✓	✓
	- Collaborate with private-sector partners to reach different market segments	✓	✓	✓
IPC/C	- Health provider IPC/C training, monitoring, and integration of messages into other MNCHN or TB services (e.g., prenatal and post-partum care, HIV/AIDS services, cervical-cancer screening,	✓	✓	✓

	Illustrative Activities	Market Segments		
		Prime the FP Market “Initiators”	Capture the FP Market “Spacers”	Maintain the FP Market “Limiters”
	childhood immunization, TB services)			
	- Rewards and recognition of “model” providers	✓	✓	✓
	- FP IPC/C job aids for WHTs/CHTs		✓	✓
	- MNCHN/FP job aids for BHWs, including storybook on MNCHN/FP for indigenous people		✓	✓
	- Train pharmacists on FP counseling and referrals	✓	✓	✓
	- “Peer counselors for health” (youth peer counselors in schools; in SK)	✓		
	- Support groups for parents of teenagers (through parent-teacher associations at school, DepEd)	✓		
	- Couples classes		✓	✓
	- First time mothers support groups		✓	
	- Insert FP messages into pre-marriage counseling classes/update existing information	✓		
Key Promise/ Positioning		- Live your life to the fullest, postpone childbearing	- Proper birth spacing of at least 2 years contributes to healthy families	- Small families help give your kids a better future
Key Message Concepts		- It is good to talk about family planning - Education first: Babies later	- Space your children 3 years apart for better health - Family planning will save you	- Small family sizes to improve the health and finances of your family - Modern family

	Illustrative Activities	Market Segments		
		Prime the FP Market “Initiators”	Capture the FP Market “Spacers”	Maintain the FP Market “Limiters”
			and your baby’s lives - Modern family planning methods are safe	planning methods are safe - Use family planning to enhance your quality of life

D. MONITORING AND EVALUATION

The overall effectiveness of the FP BCC strategy will be assessed through both process and impact evaluation.

Process Evaluation

Process evaluation, or monitoring, will be conducted and will actively involve key stakeholders on national and local levels. The purpose of the process evaluation will be to determine whether activities and outputs are proceeding and produced according to plan, and if not where necessary changes need to be made. In addition, it will examine the strengths and weaknesses of the program activities. The key indicators will cover: implementation of planned project activities such as BCC training initiatives; number of people trained; number of LGUs covered; number of health events sponsored; number of people who attend health events, community outreach and other activities by type; numbers of materials produced and distributed; number of people reached through mass media (radio, television, internet portal), etc. Specific activity indicators will be developed in accordance with the BCC operational plans. The indicators will be tracked by administrative records maintained by CHDs MIS, clinic/facility-based program data, health events (HE) tracking tools, media tracking and media habits tracking, and reporting forms compiled at provincial and LGU levels.

Impact Evaluation

Impact evaluation will be used to assess whether the right messages are coming across to the target audiences (i.e. information on the target audiences' knowledge, benefits of FP, and misperceptions) and the net effect of the strategy on the target audiences' behaviors. To track changes in knowledge and behavior indicators, DOH will:

1. Identify a core set of 5-6 FP indicators for provincial-level tracking. Track key indicators through FHSIS, and/or surveys conducted by different partners. Data will be collected annually.
2. Gather data from surveys (conducted by different partners) for collecting in-depth data to review success of the BCC campaigns and its key FP messages provided through IPC/C, community mobilization, health events and advocacy efforts. These survey provinces will be selected randomly. In each survey province, DOH will collect data from a number of households to be based on power calculations. The survey data may be gathered from different partners or by an external research group.

Key Indicators and Sources of Data

Tables 3 and 4 outline illustrative indicators for DOH FP BCC strategy and the sources of data that can be used in both the process and impact evaluations.

Table 3: Illustrative Indicators and Sources for Process Evaluation/Monitoring

Process Evaluation/Monitoring			
Level	Results	Indicators	Sources
Activities	Mass media/ health events	Number of people that have heard or seen a specific USG-supported FP message	HE tracking tools; media tracking
	Community mobilization/advocacy	Number of people that have seen or heard a USG supported FP message Number of immediate influentials mobilized to encourage people to visit health facilities for MNCHN/FP	HE tracking tools; media tracking
	IPC/C	Number of providers trained in IPC/C Number of people counseled in FP Numbers of health workers and health providers where quality of interpersonal interaction skills for FP improved	HPC tracking tools
Inputs	BCC Planning	Number of LGUs assisted in developing their BCC plans, including BCC for FP Number of LGUs trained on BCC planning	BCC implementation plans
	Capacity Building	Number of people trained in FP	Training inventory

Process Evaluation/Monitoring			
Level	Results	Indicators	Sources
		Number of LGUs implementing a FP BCC Plan	Training measures Project reports
Resources	Training modules	Number of training modules developed by type of HPC activity	Inventory
	Job aids	Number of prototype FP job aids produced and distributed to service providers	Project reports
	IEC materials	Number of prototype IEC materials developed in FP	

Table 4: Illustrative Indicators and Sources for Impact Evaluation

Impact Evaluation			
Level	Results	Indicators	Sources
Prime the FP market: Initiators			
Outcome (Behavioral objective)	Increase use of modern contraceptives by 15-24 year olds	% of 15-24 year olds using a modern method of contraceptive	FHSIS
Output (Communication)	Increase accurate in-depth knowledge about fertility, FP, and healthy timing of	- %age of 15-24 year olds who know about the fertile period during the ovulatory cycle	Surveys from different partners

Impact Evaluation			
Level	Results	Indicators	Sources
objectives)	pregnancy	- %tage of 15-24 year olds who know of any modern contraceptive method, by specific method - %tage of 15-24 year olds who know about healthy timing of pregnancy (i.e. timing of first pregnancy and succeeding pregnancies)	Activity post-tests/measurements
	Increase numbers of young people who know where to go seek modern contraception if needed	% of young people ages 15-24 who know where to go for FP health services	Surveys from different partners
Capture the FP Market: Spacers			
Outcome (Behavioral objective)	Increase % of currently married women with 1 child using any modern method of FP	% of currently married women using a modern method of contraceptive, by number of living children Number of men and women who endorse the practice of FP to others Number of couples that discuss the use of contraceptives	FHSIS, Surveys from different partners
Output (Communication objectives)	Reduce number of women citing fear of side effects as a reason for non-contraceptive use	% of currently married women and men electing not to use modern contraceptives, by reason	Client survey
	Increase accurate in-depth knowledge about	Number of married women with increased knowledge of relationship of healthy birth spacing and healthy birth	Activity post tests/measurements

Impact Evaluation			
Level	Results	Indicators	Sources
	relationship of healthy birth spacing and healthy birth outcomes	outcomes	

Maintain the FP market: Limiters			
Outcome (Behavioral objective)	Increase% of currently married women and men with 2+ children using any modern method of contraception	%tage of currently married women and men with 2+ children using any modern method of contraception, by method Number of men and women who endorse the practice of FP to others Number of couples that discuss the use of contraceptives	FHSIS, Surveys from different partners
	Increase use of long-term and permanent methods	%tage of currently married women and men with 2+ children using any modern method of contraception, by method	FHSIS
Output (Communication objectives)	Increase favorable attitudes towards small family size	Number of men and women who can state at least two benefits for promoting smaller family size	Surveys from different partners
	Increase use of long-term and permanent methods	%tage of currently married women and men using long-term permanent methods of contraception	FHSIS

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