


Elevating Social and Behavior Change as an Essential Component of Family Planning Programs

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The global family planning community has made significant progress towards enabling 120 million more women and girls to use contraceptives by 2020, though we enter the decade ahead with a long road yet to travel. While investment in strong health systems and supply chains is still needed, the supply-driven approach dominant in family planning fails to address the individual, relational, and social barriers faced by women and couples in achieving their reproductive intentions and desired family size. Overcoming these barriers will require a better understanding of behavioral drivers and the social environment in which family planning decisions are made, and an increased investment in the proven, yet underutilized, approach of social and behavior change (SBC). We make the case that a more intentional focus on the science of human behavior in family planning can help advance the achievement of global, regional, and national goals while also calling for strategic and sustained investment that reflects the critical importance and proven impact of SBC approaches.

INTRODUCTION

In 2012, the global family planning community committed to enabling 120 million more women and girls to use contraceptives by 2020. While we have seen significant progress, with 60 million additional users since 2012 (FP2020, 2020b), the 120 million goal was not met. We need to do more, and do it better, and we need to do it now. This year presents an

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inflection point; the United Nations Population Fund (UNFPA), the Bill and Melinda Gates Foundation, and FP2030 are each using this moment to define ambitious strategies for the next decade. These and other global partners have rallied together to create a new vision for 2030 that builds on progress to date and provides collective inspiration for what we need to achieve.

Over the past two decades, the emphasis of family planning programs has been skewed towards provision of commodities and services, following the commonly cited mantra of “no product, no program,” which sought to improve security of reproductive health commodities (Hart, 2004; USAID 2006; Solo, 2011). While investment in strong health systems, supply chains and commodity security is critical, the current supply-driven approach fails to sufficiently address the many social and behavioral barriers faced by women and couples in achieving their reproductive intentions and desired family size. Overcoming these barriers will require a better understanding of behavioral drivers and the social environment in which family planning decisions are made, along with an increased investment in social and behavior change (SBC) approaches.

SBC is a discipline that employs deep understanding of human behavior and uses evidence-based interventions at the individual, community, and societal levels to support the adoption of healthy practices. SBC approaches also influence underlying social and gender norms that may facilitate or inhibit individuals from making and acting on their decisions. SBC programs aim to create a supportive normative environment for women, men, girls, and boys to set their own reproductive intentions and access modern contraception. As a discipline, it draws on areas including communication, social psychology, anthropology, behavioral economics, sociology, human-centered design, and social marketing (Glanz, Rimer, and Lewis, 2002; HIPs, 2018b).

Critical barriers to increased and sustained investment in SBC include a lack of awareness of the body of supporting evidence, a misunderstanding of what constitutes high-quality SBC, and a focus on short-term results (Breakthrough ACTION, 2018). Consequently, global and national strategies to increase family planning use often fail to sufficiently acknowledge the essential role of SBC. For example, while all Costed Implementation Plans (CIPs) include a “demand creation” component,¹ a recent analysis of 36 CIPs revealed that the budget for demand creation as a percentage of the total CIP budget varied significantly, from less than 1 percent to just over 30 percent. Of these, more than one-third had demand creation at less than 12 percent of the CIP budget (FP2020, 2020a).

Further analysis of 27 country CIPs revealed the budget for demand creation per woman of reproductive age (WRA) ranged from less than US\$0.50 (Bangladesh, Ethiopia, Burundi) to over US\$6.00 (Liberia, Mali, Zimbabwe) with an average of US\$2.80 (FP2030, 2020). The countries with the higher demand creation budget per WRA have the most detailed descriptions of SBC strategy with multiple activities described. For example, Zimbabwe’s demand creation strategy is based on formative research; mass media activities are tailored to the outcomes of studies; and other activities include community group engagement, interpersonal communication, and social marketing, among others. Countries with the lowest demand creation budget per WRA (Bangladesh, Ethiopia) either did not cite an SBC

1 This term is often used to denote a range of SBC activities, though SBC is used for more than just demand creation

strategy or mentioned that it was being developed and included only limited descriptions of activities. While the right balance of funding depends on country context, low investment in demand creation is likely limiting impact of investments in service delivery.

A more intentional focus on the science of human behavior can help advance the achievement of global, regional, and national family planning goals, hence our call for strategic and sustained investment that reflects the critical importance and proven impact of SBC approaches. In this article, we demonstrate that (1) significant social and behavioral barriers to family planning uptake and continuation remain in many settings; (2) SBC approaches to address these behavioral drivers are evidence-based and cost-effective; and (3) investments in SBC enhance those made in service delivery.

SIGNIFICANT SOCIAL AND BEHAVIORAL BARRIERS TO FAMILY PLANNING UPTAKE AND CONTINUATION REMAIN IN MANY SETTINGS

In many places where family planning use lags behind desired fertility preferences, social and behavioral barriers continue to prevent potential clients from demanding, accessing, and using modern contraceptives. For example, an analysis of Demographic and Health Survey data from 51 surveys found that concerns about side effects or the inconvenience of methods were a primary reason of nonuse among 35% of married women in Latin America and the Caribbean, 28% in Africa, and 23% in Asia (Sedge and Hussain 2014). Outside of West Africa, lack of awareness, lack of source of supply, or prohibitive cost are rarely cited by women with unmet need for contraception as reasons for nonuse. Perceived lack of need due to breastfeeding or infrequent sex is also a major reason for nonuse, suggesting that women may underestimate their risk of pregnancy (Sedge, Ashford, and Hussain 2016).

A substantial body of evidence also demonstrates the importance of social and gender norms on family planning and contraceptive use. For example, women and girls may derive social and economic status by conforming to social expectations about womanhood and motherhood (McCleary-Sills, McGonagle, and Malhotra 2012). These social expectations include pressure to prove fertility soon after marriage and/or puberty (Jejeebhoy, Santhya, and Zavier 2014) and pressure to have large families or son preference (Mason and Smith 2000; Hussain, Fikree, and Berendes 2000). Fear of social stigma and disapproval, as well as fear of active opposition, are also reasons given for nonuse of contraception (Casterline and Sinding 2000; Williamson et al. 2009). A range of research has further documented a strong link between a woman's level of empowerment in the domestic and social spheres and her ability to make and act on reproductive decisions (Jejeebhoy 2002; Govindasamy and Malhotra 1996).

The maximum contraceptive prevalence “demand curve” provides a simple assessment to help inform the balance needed between investments in expanding family planning services and investments needed to address social norms and behaviors (Weinberger et al. 2017). For countries that sit far below the curve (large potential use gap), growth in modern Contraceptive Prevalence Rate (mCPR) is likely to be less constrained by low levels of demand, though integration of SBC into service delivery could still strengthen programs. By contrast, for countries that sit near to the curve (small potential use gap) further gains in mCPR are

unlikely without changes in demand. In these contexts, a focus on service delivery alone is unlikely to lead to much change in contraceptive need and use.

An innovative new study explored the role of both supply- and demand-side factors on increasing contraceptive use (Miller, de Paula, and Valente 2020). The study, which employed structural modeling on the subjective expectations and probabilistic beliefs of women in Mozambique, found that typical supply-side interventions are unlikely to effectively increase contraceptive use: even the most dramatic (and costly) increase in supply, removing all direct and indirect monetary costs of contraceptives, eliminating waiting times, and removing uncertainty about availability increases contraceptive prevalence by only 1.1 percent. Alternatively, the analysis found that demand-side interventions are more likely to be effective: For example, increasing women's expectations that their partners will approve available forms of contraception by 25 percent raises contraceptive prevalence by 3.6 percent (Miller, de Paula, and Valente 2020).

These studies should not be understood as pitting service delivery against SBC approaches, but to emphasize the importance of addressing social and behavioral factors and the impact that such interventions can have on family planning outcomes. In sum, to fully understand nonuse of modern contraception, family planning programs need to consistently and systematically apply a behavioral lens to identify barriers and implement strategically designed SBC interventions. More attention is also needed to diagnose the social and gender norms related to family planning use, along with broader social determinants of health, and to improving the integration of social norms shifting interventions into family planning program design. At the same time, there is a need to more explicitly consider the ethics of social norms interventions and make ethical reflection a consistent part of SBC design and implementation (Igras et al. 2020).

SBC APPROACHES TO ADDRESS BEHAVIORAL DRIVERS ARE EVIDENCE-BASED AND COST-EFFECTIVE

After five decades of implementing and evaluating SBC strategies in the health sector, robust evidence demonstrates that at-scale SBC programs play a key role in improving health outcomes. Some of the earliest evidence for the impact of SBC programs comes from family planning, where SBC has been shown to generate demand, improve interpersonal communication between providers and clients, and shape supportive social norms (Lieberman 1972; Bailey 1973).

Questions are often raised as to what SBC interventions are most effective. The Family Planning Goals Impact Matrix has calculated impact estimates on use of modern contraceptives based on a single comparable metric (odds ratios [OR]) for three specific SBC approaches documented in the HIPs. The matrix found that each approach had a positive impact on contraceptive use (mass media: median OR = 1.29; interpersonal communication: median OR = 1.51; and community group engagement: median OR = 1.29) (Weinberger et al. 2019).

Evaluations of SBC programs support this modeling, demonstrating that a variety of approaches are successful at improving family planning outcomes, including working with

religious leaders to create normative support for family planning within religious teachings (Adedini et al. 2018; Speizer et al. 2018), engaging men and working with couples to challenge inequitable gender norms and power relationships and improve couple communication (Doyle et al. 2018; Lemanj et al. 2017; Subramanian et al. 2018), promoting role models and demonstrating pathways to change through mass media (Jah et al. 2014), and engaging communities through dialogues, communication, and empowerment (Wegs et al. 2016). The evidence also shows that SBC can influence family planning-related discussion and behavior even among those not directly exposed to interventions, demonstrating the diffusion power of high-quality SBC (Boulay, Storey, and Sood 2002).

Modeling for Zambia and Guinea has also demonstrated that SBC is a highly cost-effective intervention. The analysis found that the cost per disability adjusted life year (DALY) averted for family planning using SBC approaches was US\$1,051 in Zambia and US\$438 in Guinea (Rosen et al. 2019). Both results fall below the one times gross domestic product per capita threshold for classification as a highly cost-effective intervention. When compared against nearly 100 health interventions in developing countries, SBC for family planning falls within the middle range of cost per DALY averted (Horton et al. 2017).

Compilation and synthesis of the evidence of SBC over the past 10 years have cemented this evidence base on the effectiveness of SBC and identified key attributes of effective SBC interventions that can facilitate replication and scale up (Initiative for Impact Evaluation 2017; Storey et al. 2011; Behavior Change Impact 2020; High-Impact Practices in Family Planning [HIPs] 2016, 2017, 2018a, 2018b). One of the most significant of these key attributes is the impact of multichannel, multidose interventions. Evaluations consistently show that the higher the level of exposure to SBC interventions, the greater the increase in contraceptive use (Babalola and Vondrasek 2005; Kincaid 2000; Krenn et al. 2014). In addition, effective interventions are commonly informed by behavioral theory, which specify the determinants of decision-making and is used to guide intervention design and persuasive messaging (Storey et al. 2011). SBC funders and implementers should therefore consider these high-impact attributes when making program decisions.

While much evidence exists, gaps do remain. For example, recent years have seen increased investment in research around social norms, but not necessarily to translating this rich body of knowledge into programmatic practice and conducting associated evaluations. Of critical importance is the need to ensure that SBC programs are implemented to a high standard, are theoretically informed and driven by ethical considerations. Greater use of integrated theoretical models, such as the Behavioral Drivers Model (Petit 2019) that ties together individual level theories of change with broader social and structural theories, would help ensure that programs are designed to address the complexity of family planning behaviors and norms and ultimately improve outcomes.

INVESTMENTS IN SBC ENHANCE THOSE MADE IN SERVICE DELIVERY

SBC is an essential component of family planning programming along the “Circle of Care,” before, during, and after the time a client accesses services. The Circle of Care framework

shows that strategic investments in SBC interventions enhance those made in service delivery (Johns Hopkins Center for Communication Programs 2017). For example, while SBC creates demand for family planning services, behavior change interventions are also valuable in building trust in services, improving provider motivation and performance, and enhancing counseling.

Experience in family planning and other health areas has demonstrated the potential of SBC to build trust in health services and improve perceived quality of care, which ultimately contributes to increased use of services (Babalola et al. 2001; Gazi, Kabir, and Saha 2014; Tawfik et al. 2014). Approaches such as community dialogues, service branding, and clinic walkthroughs and makeovers ensure that services are attractive, high quality, and responsive to the communities they serve. SBC has also been successfully used in social accountability initiatives for family planning; these initiatives emphasize mutual respect and responsibility between communities and health care systems, which work together to identify problems in family planning service provision and activate community-led improvements as a means to improving health outcomes (Gullo et al. 2017; Results for Development Institute 2014).

Clear evidence also demonstrates that provider behaviors impact how clients perceive health services and ultimately determine whether they adopt and continue to use family planning. Provider performance is influenced not only by knowledge and clinical skills but also by norms within facilities and communities, personal bias, and time and resource constraints—all factors that are ideally addressed through SBC approaches (Neukom et al. 2011; Health Communication Capacity Collaborative 2015; Sanders and SHOPS Project 2012). Indeed, evidence shows that SBC interventions can improve provider motivation, efficiency, and empathy to improve quality of care (Ahmed et al. 2015; Chandra-Mouli, Lane, and Wong 2015; Kamhawi et al. 2013; Kim et al. 2005).

The application of evidence-based behavior change strategies can also improve service-based counseling, which is essential for voluntary, informed choice and can help address multiple barriers to family planning uptake. Although attention to interpersonal counseling has ebbed and flowed over time, stakeholders in family planning have increasingly called for taking a client-centered approach, one that is based on mutual respect and takes into account clients' values, preferences, and experiences (Schivone and Glish 2017; Dehlendorf, Krajewski, and Borrero, 2014; Marshall et al. 2017).

Looking forward, program partners can seize opportunities to strengthen service delivery through behavioral thinking and interventions. For example, experience in a range of countries increasingly suggests the potential to apply human-centered design to improve health service delivery. These efforts need to be documented, expanded, and evaluated, with necessary adjustments for evaluation methodologies (Doyle et al. 2019). Furthermore, programs should also increase understanding of the role of social norms in the context of health services, and design and evaluate effective norms-shifting interventions targeted at providers. These interventions must be designed and implemented in partnership with providers, facilities, and health systems, and they must avoid vilifying or dismissing providers as barriers to client access. Moreover, interventions to maximize provider performance must be paired with interventions to empower clients and build trust and accountability between providers, clients, facilities, and communities.

CONCLUSION

The commitment of governments, donors, and implementing partners to family planning over the past three decades has transformed the lives of women and families worldwide. In many settings, expanded access to family planning commodities and reproductive health care have satisfied latent demand by girls, women, and couples to time pregnancies while achieving educational goals, equitable relationships, and economic empowerment. What lies ahead will be harder. We must address social and behavioral barriers to demand, access, and use, and we must also ensure that family planning programming is ethical, equitable, scalable, and sustainable in the face of reduced donor funding and competing public health priorities.

As we travel this road, the family planning community must continue to increase the quality, reach, and impact of SBC programs and do more to support and empower local stakeholders to design, implement, and monitor SBC interventions in their own context, recognizing and embracing complexity. Doing so will necessitate both increasing strategic and sustained investment in SBC, not only by donors, but also by governments and private sector partners, and coordinating investments to support national priorities at scale to avoid duplication of effort.

The family planning community has set an ambitious collective vision for the decade ahead: aspiring for “a future where women and girls everywhere have the freedom and ability to lead healthy lives, make their own informed decisions about using contraception and having children, and participate as equals in society and its development” (FP2030, 2020). This vision can be achieved if we build on our strong foundations in commodity security and service delivery with SBC interventions that put people at the center of our work. “No product, no program,” may be true; but family planning programs must put equal emphasis on behavioral drivers and the social context in which people make family planning decisions. Increased prioritization of, and sustained investment in, SBC approaches will help to increase the voice and agency of millions of women, men, girls, and boys, enabling them to define their own reproductive lives, fertility intentions, and aspirations for the future.

DISCLOSURES

The views expressed herein are those of the author(s) and do not necessarily reflect the views of their institutional affiliations. The authors have no conflicts of interest to disclose.

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