Review of effective marketing and demand creation strategies in HIV Prevention and Family Planning that may inform demand-side thinking for the Dual Prevention Pill (DPP)

APRIL 2022

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Introduction & Background

Purpose of scoping review

As we design demand creation for the Dual Prevention Pill (DPP), we need to ensure lessons from previous demand generation interventions in HIV prevention and Family Planning (FP) are utilized by addressing known barriers for both oral pre-exposure prophylaxis (PrEP) & oral contraceptives (OCs), and employ effective strategies for creating sustained demand for interventions (e.g., VMMC, condom use, FP).

This scoping review aims to **document effective and sustainable demand creation strategies** used in HIV prevention & FP interventions, **how they may be adapted for the DPP** and explores **what could be done differently for the DPP**.

Dual Prevention Pill (DPP)

- *In East and Southern Africa (ESA), 65% new HIV infections in women ages 15+*
- *In ESA, 16% women of reproductive age have unmet need for contraception*
- *Contraceptive multipurpose prevention technologies (MPTs) have potential to overcome uptake/adherence challenges and stigma with oral PrEP/HIV services*
- *DPP is cisgender woman-centred and controlled daily oral pill for HIV and pregnancy prevention*
- *DPP will initially focus on women ages 20-40, who have higher rates of OC/oral PrEP use and oral PrEP continuation; likely to be early adopters*

The Dual Challenge & Opportunity

DPP likely to face combination of challenges experienced in oral PrEP and OC uptake, including:

- Burden of taking daily pill
- Stigmatization of oral PrEP
- Provider bias/judgement, esp. towards younger women & key populations
- Fear of side effects
- Lack of partner support

Review of literature on PrEP demand creation found:

- Uneven application of user-centred design, demand-side thinking
- Limited evidence on effective & most cost-effective interventions
- Varying regulations on how specific drugs can be marketed in different countries
- Opportunity to adapt demand-side thinking, a comprehensive range of strategies, approaches and specific mindset

Shifting mind-sets and approaches

- ***From 'Demand Creation' to Demand-side Thinking***
- ***From Risk to Reward: relationship goals & sexual pleasure***

Review Objectives

- Identify **effective and sustainable demand-side interventions** for HIV prevention and FP and how both can inform marketing of the DPP

- Identify **potential solutions for sustaining demand and investment** in demand generation strategies

- Inform **what should be done differently** for the DPP and other newer HIV prevention interventions

Methods

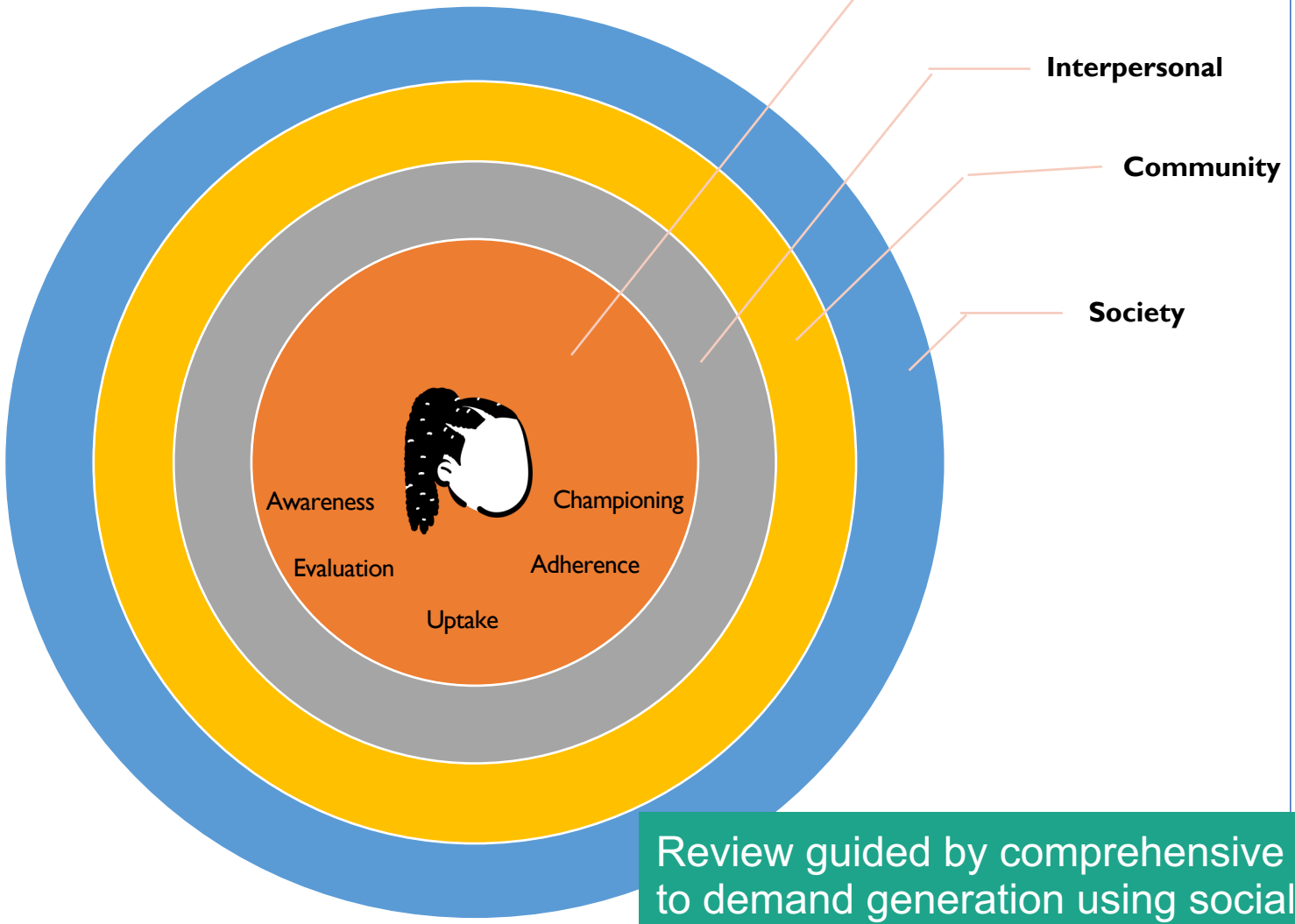
- This document contains findings from a **review of clinical and implementation research papers** published in renowned journals and evidence-based program reports from 2014-2021
  - Search conducted using Web of Science, Embase, PubMed, Google Scholar, PrEP Watch
  - 46 documents were reviewed. Of these:
    - 28 studies were reviewed, of which 18 met search criteria and were included; 3 additional studies conducted before 2014 whose findings most likely impacted current interventions were included for their relevance
    - 18 of the documents reviewed comprised of programmatic reports
  - Significant number of strategies focused on PrEP, VMMC, condoms, FP, successful related programs
  - Randomized clinical trials, longitudinal and cross-sectional study designs and programs for FSW, AGYW, young men, healthcare workers
  - Evidence of successful practical strategies for demand creation for HIV prevention and FP products/services
- When **analyzing the results** of this desk review, we reference the following SBC theories:
  - Transtheoretical Model (TTM), AKA Stages of Behavior Change
  - Social Ecological Model (SEM)

Policy | Regulation | Financing

The Product (Dual Prevention Pill)

Supply Chain

Service Delivery



Review guided by comprehensive approach to demand generation using social-ecological and transtheoretical models

Convergence & divergence in FP & HIV demand generation

- The need to **shift demand generation interventions** for both FP & HIV based on risk motivation to reward motivations such as pleasure, empowerment and relationship goals
- In both cases, there is need to **employ a cocktail of SBC strategies**, or 'surround sound' approach, to bring about desired change
- The need to **customize the demand generation strategies** through a process that considers cultural realities, needs of population & literacy rates
- Community acceptance is a huge impediment for uptake of both HIV & FP, hence the need to **identify and appropriately engage key community influencers**
- The FP sector is way advanced in creating demand for choice, an area that the HIV sector needs to build on in the era of increased HIV biomedical products – offering choice in HIV prevention

Addressing gaps along DPP pathway to adoption

1. Awareness

Goal	How Might We….	What has been done in other HIV prevention & FP interventions	How interventions contributed to increased uptake
Develop education & demand creation strategies to combat barriers for each awareness step	**Increase awareness of DPP/ Help her understand product & benefits** • Help her overcome concerns • Build her confidence that she'll be successful if she tries (make it easier for her)	• *Jilinde* employed **national mass media & regional events/ roadshows** to introduce & create mass awareness of PrEP in Kenya • *Kuwa Mjanja (*A360 in Tanzania) used **skills-building pop-up events as entry point to SRH conversations**, awareness, service delivery. *Brighter Future* events used for quick skills- learning, bead-making, makeup sessions, PrEP/FP awareness & services • *Brighter Future* used **Incentivized Peer referral system** for PrEP/FP for AGYW. Leveraged trusted friends & peer networks; once target audience received PrEP/FP services, asked to refer/bring friend to facility & rewarded with non-monetary incentive • **Targeted/themed events,** e.g., *Urembo Wednesday* (make-up/beauty sessions with PrEP/FP intertwined), *Juice Friday* for FSWs at Drop-in Centres (DICEs). Provided skills-building activities to FSWs; asked to refer/bring friends	• *Jilinde's* national mass media activities helped reduce chances of PrEP being stigmatized. In Migori, broad awareness building/market activation campaigns helped increase awareness from 30% to 70% and saw large increase in oral PrEP uptake • *Kuwa Mjanja:* 71% AGYW voluntarily took up modern contraceptives (51% LARCs) • *Brighter Future* events & safe spaces: 41.8% AGYW enrolled on PrEP, esp. AGYW with limited opportunity who are concerned to see relatives at health facilities • Incentivized peer referral system, *Brighter Future* events, peer networks: 170% increase in oral PrEP uptake among AGYW compared to period when only peer education used

2. Evaluation

Goal	How Might We….	What has been done in other HIV prevention & FP interventions	How interventions contributed to increased uptake
Understand what she's looking for in DPP (product);	**Make DPP more attractive & mitigate impact of features that don't align with the ideal** • Product attributes and packaging • What information is she seeking to make a decision and where is she getting it from	• **Community mobilization:** To address deeply ingrained beliefs & customs, often necessary to bring together cultural custodians for dialogue to address Harmful Traditional Practices (HTPs) • Oct. 2018-Sept. 2020: *Afya Halisi* project (Kenya) brought together 50+ FBO leaders to dialogue & give direction to *Kavonokya* community in Mwingi County that outlawed any form of health facility visit for members & taking modern medicine • For years, *VMMC program* in Luo Nyanza faced stiff opposition from locals against the procedure ("against their culture"). Well-orchestrated dialogue session convened Luo Council of Elders; then-Prime Minister Hon. Raila Odinga made declaration accepting & endorsing VMMC, resulting in massive turnout for VMMC over several months • **Direct Endorsement:** Elton John AIDS Foundation & PS Kenya ran CHUKUA SELFIE (CS) campaign using local celebrity champions to endorse messages to vulnerable young men 18-24 years with information on HIV, including where to securely source self-care products, e.g., HIV self-testing kits and condoms	• After series of meetings, Kavonokya elders consented to using mosquito nets & HH water treatment solutions but were still adamant on issues like FP and skilled facility delivery • Oct. 2008-Sept. 2011: VMMC partners in Luo Nyanza circumcised over 287,026 men, an accomplishment made possible through combination of innovative SBC strategy and supportive government leadership • *Chukua Selfie* campaign reached over 3.6M people and had 2.12M YouTube views. GeoPoll survey: 316 respondents bought & used HIVST kit after seeing CS ads

3. Uptake

Goal	How Might We….	What has been done in other HIV prevention & FP interventions	How interventions contributed to increased uptake
Understand criteria for ideal DPP service delivery experience for women aged 20-40 & what's needed to provide that level of care	• Understand expectations of women, acceptability of alternative service delivery options (esp. for new options from de-medicalization) • Support healthcare providers to counsel clients • Help women cope with side effects	• **Moonlight Hotspot outreach** for PrEP/FP for FSW (Kenya) • *Jilinde* and *DREAMS* AGYW program (Kenya) utilized **Outreach at Community Safe Spaces** to offer HIV/FP services to AGYW; provided non-judgmental, integrated services • **Youthful/youth-friendly peer educators & providers** ran Jilinde/DREAMS safe spaces, offering youthful, dedicated services to AGYW • **Task-shifting/employing lower cadre of staff** for FP programs: community health workers (CHWs) distribute commodities & provide services to bring health services to communities (Ethiopia, Kenya, Malawi)	• Task-shifting & community-based distribution helped increase access for SRH products/services & de-medicalized services. In Malawi, task-shifting DMPA to Health Surveillance Assistants saw 31-fold increase of clients accessing it (3,210 in Mar. 2009 to 101,885 in Mar. 2011)

4. Adherence

Goal	How Might We….	What has been done in other HIV prevention & FP interventions	How interventions contributed to continued adherence
Understand strategies for breaking down internal & external barriers to adherence for DPP	• Help her deal with side effects if/when they occur • Support her during changing circumstances & stigma • Help her get back on track if she's discontinued use • Offer tailored adherence support • Reach & engage male partners	• **PrEP Buddies/Treatment as Prevention (TaSP) buddies/supporters** (South Africa, Kenya) leveraged trusted relationships to support users with reminders, side effects, refills to ensure adherence • **Community adherence clubs** in Cape Town led by CHWs, supported by nurses where members send client-nominated treatment supporter/'buddy' to collect ART at alternating group visits • **Adherence counsellors** at facilities work closely with CHWs to conduct loss-to-follow-up tracing in HIV treatment programs • *PrIYA* (Kenya): **Integration of oral PrEP at scale** in routine services in public maternal/FP clinics for AGYW • *PrEPmate* (USA): **mHealth intervention** with SMS & youth-tailored web content + standard of care (SOC), prevention support (risk assessment, PrEP education, adherence/risk-reduction counseling) for at-risk YMSM	• Study in Kisumu, Kenya among clients living with HIV: females with treatment buddy 28% more likely to adhere to all appointments than those without • Adherence clubs: 94% adherent to treatment after 1 year • PrIYA: PrEP continuation 38% for participants & 68% for those with HIV-positive partner, showing feasibility of integrated services • PrEPmate improved retention in PrEP care, PrEP adherence/ persistence. Significantly larger % visits completed by program participants (86%) vs. SOC (71%)

5. Championing

Goal	How Might We….	What has been done in other HIV prevention & FP interventions	How interventions contributed to continued adherence
Develop strategies to break down resistance to championing HIV prevention & FP to turn gatekeepers into advocates	• Help women feel more comfortable sharing their SRH stories • Promote or engage partner / peer / community / providers	• **Peer system among FSW, AGYW** for PrEP & general SRH services; peer groups comprised of trusting, closely-knit members from same population groups, with peers accountable to each other to create trust & confidence in information shared (e.g., *DREAMS project* in Kenya) • *Bar Hostess Empowerment & Support Programme (BHESP)* (Kenya) implemented ***Topanda Peer Education Model*** to raise awareness on HIV risk & PrEP • **Male inclusion in support of FP uptake**. Men are general resource holders and in most patriarchal communities in Africa want/expect to decide how many children to have. *Tupange project* (Kenya) & others in Africa included strategies to reach men, encourage them to support women to take up FP	• *BHESP project* reached 5,469 AGYW with PrEP services, raised awareness of HIV risk & PrEP for 18,525 young people • Qualitative study in eThekwini District (South Africa) in community & healthcare settings revealed complex, evolving role of male partners in FP uptake/ use, including social support, adequate information, shared responsibility that affect uptake & continuation of FP by women

Most promising strategies for DPP demand creation

1. Peer Strategies

Intervention	Specific Examples	Outcome / Evidence	Recommendations / considerations for DPP
Peer-to-peer approaches (P2P) • *Peer Coaching* • *Peer Support Groups (PSG)* • *Small Group Sessions (SGS)* • *Peer Education - One-to-One* • *Word of Mouth (WOM)* • *Social Networking Strategy (SNS) - Snowballing and/or Referrals*	• Most PrEP interventions rely on community mobilization model + modest investments in mass media. *Jilinde's* shift to Youth Peer Provider model (YPP) led to sharp increase in AGYW enrollment, drove 80% of youth initiating PrEP to facilities. Peer education successful in promoting VMMC, HIV, FP services among adolescents & young people in Mount Darwin (rural) & Bulawayo (urban) (Zimbabwe) • *DREAMS Project* employs EBIs (e.g., Sister to Sister, SHUGA, Families Matter, Healthy Choices, SASA!, etc.) facilitated through SGS or One-to-One engagements. Works through established community structures, e.g., CHS, with additional leeway of on-boarding satisfied clients & female champions	• PrEP users with social support from peers improved self-efficacy, adherence barriers. Program recorded uptake of 68.5% (VMCC), 80.3% (FP) consecutively • >200 safe spaces set up in Migori & Homa Bay counties benefitting >7,500 AGYW including improved access to youth-friendly FP, HIV, GBV services • 2018: none of 65,176 girls under project sero-converted & only one of 27,916 girls sero-converted in 2019 • 5,191 girls supported with school fees in 2019. 100% of 5,315 girls supported with school fees in 2018 graduated	• For products & services that do not yet have widespread acceptance, P2P are most effective at identifying potential beneficiaries, creating awareness, linkages to care & supporting adherence. • Peer strategies model provides opportunity to create DPP champions • Women prefer safe spaces among peers for discussing intimate details of their lives. Training & supporting peers with job aids can turn them into effective mobilizers & change agents

2. Community-led strategies

Intervention	Specific Examples	Outcome / Evidence	Recommendations / considerations for DPP
CHV led Community & Household Dialogue Sessions • *Barazas/townhall sessions* • *Small Group Sessions* • *Couple Counselling* • *One-to-One sessions (e.g. Adherence Counselling for HIV)* • *Ad hoc Social Gatherings e.g. Funerals, and Weddings* • *Community-Based Distribution (CBD) strategy can be layered into CHS to improve access to products* • *Referrals/escorting clients for services* • *Informatics & Reporting relevant programmatic data & feedbacking (Also: Early identification & tracking)*	• *EVIDENCE Project* piloted strategies to build capacity of CHVs to offer integrated FP/HIV counseling & referrals • *Pangaea Zimbabwe AIDS Trust (PZAT)* runs DICE in private facility; initiated 300+ clients on PrEP. Outreach workers, peer educators, community adolescent treatment supporters provide follow-up/adherence support • Nepal's Ministry of Health and Population employed CHWs + mobile technology to deliver client-centered, home-based antenatal & postnatal counselling on FP use	• Increase in proportion of HIV-positive women who reported using FP method in all three arms ($p<0.05$) • Proportion of women satisfied increased significantly. Most indicated convenience, ability to receive more than one service, perceiving CHVs as friendly & trustworthy and confidentiality & privacy as reasons they would be open to receiving FP services from CHVs • PrEP continuation rates 85-90% from CHW-provided education, follow-up, adherence support • In Nepal, modern FP use increased from 29% to 46%	• Community Health Services platform is currently most extensive platform in most African countries available in healthcare space for conducting SBC & other community engagement activities. • CHVS have been repeatedly trained in RH/FP & HIV and portend a ready force of facilitators who can rapidly deploy for DPP interventions

2b.Community led strategies

Intervention	Specific Examples	Outcome / Evidence	Recommendations / considerations for DPP
FBOs/CSO led community dialogue sessions, social mobilization & advocacy actions • *FBOs/CSOs own health facilities, conduct outreach* • *Using pulpit to engage FBOs congregations* • *FBO/CSO leaders as gatekeepers with necessary agency to influence decisions* • *CSOs may also include Self-Help Women & Youth Groups; some organized groups, e.g., Sports Clubs, may be considered CSOs in infancy*	• Faith to Action Network (FTAN) is FBO that draws membership from across most religious faiths in Kenya (Christian, Muslim, Hindu, Buddhists, Bahai, etc.). Under *Delivering Equitable and Sustainable Increases in Family Planning - DESIP Project (DESIP) Project*, FTAN membership supported consortium to conduct advocacy to improve access to FP among rural & other marginalized populations	Between 2019-2020: • Brokered consensus around age-appropriate sex education • Contributed to 17 policy changes on SRHR & women's rights • Conducted 2,215 outreach to 15,678 women & men with information on FP through faith platforms • 2 demonstration projects provided FP services to 132,550 women (143,425 CYPs)	• Collective size of CBO membership & FBO congregations significant & can be leveraged to drive change • FBO/CSO leaders are able gatekeepers with agency to influence decisions • FBOs are trusted source of information that can be leveraged to drive change • CSOs/FBOs with capacity can conduct outreach to last mile reaching underserved pockets of population

3. Men's engagement strategies

Intervention	Specific Examples	Outcome / Evidence	Recommendations / considerations for DPP
Male partner engagement **Men's engagement**	• *SAHAN project* in Somalia piloted '**The Men's Club**' intervention to increase men's knowledge on MCH & shift men's attitudes, beliefs & perceptions on their role in MCH decisions & practices. Intervention executed through series of sessions facilitated by male community influencers in places men regularly congregate for social activities • PSI's *Coach Mpilo* model reframes HIV counselor/case manager as coach & mentor who provides ongoing guidance & support–borne out of personal experience–from point of diagnosis to point of viral suppression & treatment stability. Recruits men who are stable on treatment & confident in speaking openly about own experiences living with HIV. They serve as coaches & mentors to newly diagnosed men, men diagnosed but never initiated treatment & men who were once but are no longer on treatment, for a myriad of reasons	• 92% of participants reported sessions very useful • 83% reported they discussed with friends what they learned in sessions; • 71% initiated discussions on ANC, birth spacing & facility delivery with families • 89% reported they were preparing financially for current pregnancy • 96% reported they were willing to continue similar conversations	• Men are more receptive when engaged by one of their own & in their 'own space' • Facilitator skills critical to effectiveness of session; need to identify male champions with good communication, problem-solving & questioning skills and appropriately train them

4. Mass media strategies

Intervention	Specific Examples	Outcome / Evidence	Recommendations / considerations for DPP
Mass media • *Radio* • *Television* • *Newspapers* • *Edutainment* • *Social marketing*	• Radio/TV HIV prevention campaign for ages 15-30 (Ghana) decreased sexual initiation in youngest cohort; increased awareness of AIDS, personal risk perceptions, condom self-efficacy; lowered perceived barriers obtaining condoms • ***Jilinde* used multi-media (360-degree marketing campaign**), e.g., mass media, social media, peer & community, events for oral PrEP (Kenya) • Over the past decade, **PS Kenya heavily invested in mass media campaigns for SBC & Socially Marketed** products like condoms & contraceptives, complimented by IECs and on-ground IPC • **DREAMS project implemented EE Evidence-Based Interventions** (*My Health, My Choice, SHUGA 1 & 2, SASA)* • HIV education in reality shows, *Me Too* campaign (Malawi); reality show '*Unscripted*' on different social issues (Kenya) • PSI used social marketing across many countries to promote condom use, FP	• Positive impacts of exposure to FP messages in media on use of modern FP methods, unmet need for FP (Ajaero et al., 2016; Bajoga et al., 2015; Oginni, Ahonsi, & Adebajo, 2015). One study (Do et al., 2020) found exposure to FP messages on TV had no direct impact on modern FP use. Young people's attention likely shifting from radio/print to social media • Media shaped Kenya's PrEP brand perception, positioning product for anyone at risk of HIV, leading to less stigma, smooth national roll-out • Media campaigns by PS Kenya were critical in introduction of most HIV prevention & FP products and services by creating mass awareness, acceptance & eventually increased use	• Mass media effective in DPP introduction (where regulations allow) to create awareness, social acceptability, strong brand for public • Need to train cohort of journalists on how best to cover DPP • While DPP can benefit from marketing rigour applied in social marketing, ensure enough resources allocated to maintain interventions • Effective mass media campaigns can be costly; Cost-Benefit Analysis should be conducted to justify price

5. Digital Media

Intervention	Specific Examples	Outcome / Evidence	Recommendations / considerations for DPP
Digital Media • *Blogs* • *Emails* • *Webinars* • *Websites* • *Online journals* • *Virtual meetings* • *Social media platforms* • *Short Text Messages (SMS)* • *Interactive Voice Response (IVR)*	• ***E-PrEP*** piloted social media-based, peer-led intervention to increase PrEP uptake in Young Black & Latinx, gay, bisexual & other MSM ages 18-29 • ***PrEPster*** uses mHealth to increase education, access, PrEP advocacy • ***weCare***: social media intervention used Facebook, texting, GPS-based mobile social & sexual networking aps to improve HIV-related care engagement & health outcomes for young MSM, trans women • ***PrEP15-19*** explores PrEP acceptability, use, adherence among adolescents (MSM, trans women) ages 15-19 (Brazil) • ***Amanda Selfie***: Chatbot with persona of trans woman engages audience on sensitive topics like STIs, sex, PrEP, combo prevention. Can identify those at higher risk of HIV, schedule PrEP appointments • ***Nivi*** uses SMS & interactive voice to bridge gap in access to FP info & services in several countries, including India, Kenya, Nigeria • ***Triggerise*** uses digital tools to conduct demand generation (targeted nudges), link clients to providers & access products (e.g., HIVST kits, condoms & emergency contraception as part of self-care package)	• *E-PrEP* hypothesized that, compared to E-Health, participants randomly assigned to E-PrEP more likely to express intention to use PrEP, greater PrEP uptake, show changes in potential mediators of PrEP uptake (knowledge, attitudes, stigma, access) • Kenya's *Triggerise* platform enrolled 277,970 users of whom 212,650 accessed SRH services using platform; Enrolment to Service Uptake Conversion rate is currently 60.5%. Of health services & products taken up, 92% were SRH services & products resulting in 313,880 CYPs	• Digital platforms present exciting prospects & unmissable opportunities for demand generation for DPP • Have intrinsic versatility & ability of platforms to relay messages in any traditional format; media is cost-effective, targeted & can be very engaging • Social media may facilitate social interaction & online word-of-mouth, and broaden reach/accelerate diffusion of info about new products • Need to put mechanisms in place to ensure accurate info, respectful engagement

6. IECs, Branding and Out-of-Home

Intervention	Specific Examples	Outcome / Evidence	Recommendations / considerations for DPP
IEC materials & Reports • *Brochures* • *Posters* • *Flyers,* • *Banners* • *Project reports* • *Technical briefs*	• *Health Communication & Marketing* (HCM) project was prolific in producing IEC materials to complement SBC approaches. Notable campaigns that effectively employed IECs included *C-WORD,* which provided correct information on FP aimed at dispelling myths & misconceptions, SIRI (integrated HIV& SRH), & "*Kitu ni Kukachora*" which aimed to improve life skills for better RH outcomes amongst the youth.	• Reproductive Health Trac survey conducted by PSKE in 2012, reported IECs ranked 2nd behind radio with 65% of interviewees (WRA 25-49) reporting "exposure to FP messages" via IECs	• When used to complement other SBC approaches, IECs can serve as powerful media for reference & reinforcing messages
Branding & Out-of-Home (OOH) channels • *Project vehicles* • *Murals* • *Signage* • *Billboards* • *Branded merchandise*	• *Communication for Healthy Communities* (CHC) provides ample justification for implementing an extensive branding campaign as viable and effective SBC approach. • Under brand name "*Obulamu*", project developed & deployed extensive branding campaign as principal SBC approach for influencing outcomes around FP/RH & HIV (HTS/VMMC) • *Kitu ni Kukachora* implemented under HCM project was one of most visible health branding strategies in Kenya in recent past to drive behavior change on FP/RH & Life Skills (Goal-setting). Branding was not standalone intervention & must be viewed as contributor to HCM outcomes. Branding strategy bundled with other equally effective SBC strategies, e.g., Mass/Digital Media, Peer-to-Peer approaches & Endorsement by champions/celebrities	• % target audience demonstrating comprehensive, correct knowledge on modern FP use increased from 51.7% to 71.3% • % individuals who approved of health behaviors/services promoted under *Obulamu* increased from 82.1% to 84.7% • % individuals who intended to adopt health behaviors/services promoted in *Obulamu* - Seeking Surgical Male Circumcision, increased from 76.3% to 84.9%	• During implementation, branding is most effective at identifying service points and the package of services to expect. • It is also an effective strategy for reinforcing is positive behaviors

7. Provider-initiated strategies

Intervention	Specific Examples	Outcome / Evidence	Recommendations / Considerations for DPP
Comprehensive Health Education • *Group Health Education sessions at health facilities (facilitated by Healthcare Providers, Community Health Assistants (CHAs), CHVs* • *Personalized & targeted SRH Counselling at health facilities* • *Health Education sessions during outreach (with SRH services, HTS, referrals)* • *Personalized & targeted SRH/PrEP Counselling at pharmacies*	• Postpartum Family Planning (PPFP) has not been implemented to WHO standards in most African countries despite irrefutable evidence of elevated morbidities & mortalities when pregnancy intervals are <12 months apart. *Afya Halisi project* (Kenya) adapted model of Group-ANC model fronted by JHPIEGO to good effect. Not only did facility deliveries drastically increase, but % providers also offering PPFP also increased, leading to favorable outcomes	• Uptake ANC & PNC package of services increased across all Halisi counties & achieved 70,967 skilled births (101%) against target of 70,002 • Of women taking up skilled facility delivery, 52% received PPFP within 48 hours of delivery. • Implants were preferred FP method	• Health Education/Promotion session critical entry points for discussions & referrals for health services, e.g., HTS, RH/FP (PPFP) & potentially DPP • As go-to authorities on health matters, HCWs need support to conduct effective Health Educ. sessions at facility & community levels
Provider Behaviour Change (PBC) & Capacity-strengthening initiatives • *Training, Coaching & Mentorship to improve knowledge, skills, attitudes of providers* • *Whole site orientation – targeting all workers at facilities, e.g. guards, cleaners* • *Counselling for Choice (C4C)* • *Provider-Initiated Family Planning (PIFP)*	• *Afya Halisi* trained technical staff from Kitui MOH (Kenya) on VSC to strengthen capacity of MOH to provide VSC & interrogate provider values/attitudes, which significantly affect service quality & uptake of modern FP • *Afya Halisi* trained 115 HCWs on novel C4C approach to interrogate HCW values/ attitudes & effect on interactions with target audiences, esp. vulnerable pops. (AGYW, refugees, IDPs, LGBTQ), and quality & uptake of services, e.g., LARC, VSC	• 136 BTLs & 10 vasectomies in 2019 in Kitui County General, Teaching and Referral Hospital • Following intensive Health System Strengthening interventions, e.g., training HCWs & other cadres in Afya Halisi counties, uptake of FP services & products in Private Sector facilities significantly increased, leading to 86,639 CYPs (11% to 16% of project targets)	• Targeted capacity-strengthening interventions required as part of systems strengthening effort for successful DPP introduction • PBC module must be sensitive to demographic peculiarities of target audience • Most useful at uptake and adherence stages of TTM

Gaps & Recommendations

Evidence Gaps

- Despite deep analysis of programs and research, **limited studies exist on demand creation for HIV prevention & FP** (especially for older women). Gaps in evidence delay refinement and scale-up of health communication strategies
- Need to conduct more **operational research to provide evidence base** for implementation of demand creation interventions
- Opportunity to identify **ongoing demand creation studies for PrEP & FP** that may be closely tracked to inform DPP demand-side thinking
- Limited studies published in credible journals on **service provider knowledge, attitudes and administration of ART** (White et al., 2012 referenced)
- Whereas there is a wealth of grey literature such as project reports, most organizations were **unwilling to have their information shared publicly**

Recommendations for DPP demand-side interventions

Overarching approach

- **Need for sustained investment in DPP demand generation** to facilitate uptake & sustain use. Lessons from condom programming indicate decreased use & subsequent loss of gains over time where resources not maintained
- **Adapt concept of 'demand-side thinking'** as opposed to finite set of mobilization activities. Requires holistic & dynamic understanding of users, the product/services – and moves beyond messaging activities to include issues, e.g., product design, delivery methods, provider capacity-building
- **Design demand generation strategies that are context specific**, informed by user needs, cultural realities & literacy rates
- **Employ a cocktail of SBC strategies or 360 degree approach** to bring about desired change
- **Consider incorporating pleasure** via a range of different demand generation interventions and in different populations
- Learnings from oral PrEP introduction in Kenya indicate **need for phased approach in demand generation** to allow for learning & iteration

Must have strategies for DPP demand-side interventions

- **Modest mass media** (where regulations allow) to create awareness, social acceptability, strong brand for the public
- **Targeted demand generation** amongst priority audiences through **interpersonal communication & social media** (where applicable)
- **Provider-initiated demand generation** strategies through building counseling skills and providing relevant tools

- *Successful demand generation strategies cannot be replicated across countries, or even within the same country, without full analysis & understanding of context & target groups. Strategies must be customized through a process that considers cultural realities, needs of population & literacy rates*
- *Programmes using multisectoral approaches, combining activities at different levels & linking health sector interventions with other types of interventions delivered through other sectors, offer the most promise in sustaining behaviour change*

(KII, Integrated SRH Implementing Partner)

Recommendations for DPP demand-side interventions

Media interventions

- **Involve media at onset of DPP introduction** (where regulations allow) to create awareness, social acceptability, strong brand positioning among public. *Train cohort of journalists on how best to extensively cover DPP*
- **Leverage social media for social interaction & online** word-of-mouth to broaden reach & accelerate diffusion of information about DPP. *Put mechanisms in place to ensure accurate information & respectful engagement*
- While DPP can greatly benefit from marketing rigour applied in social marketing, **ensure enough resources are available to maintain intervention**

Service delivery / Point of care

- **Develop provider training curriculum** to build technical skills on DPP; **incorporate client-centred approach** using shared decision making, trust-building, customer satisfaction techniques to maximize quality of care
- **Incorporate DPP as part of minimum service package** offered for YFS
- **Establish cadre of mentor models/champions & incorporate values clarification training** to address provider bias

Recommendations for DPP demand-side interventions

Community & peer led interventions

- **Build on existing approaches and spaces for women** and by people they trust
- **Train & support the peers / trusted agents with DPP communication tools/job aids** to facilitate counseling, education, mobilization
- **Identify & strengthen linkages to interventions** that support women to communicate with their partners and engage men in women's health
- Where applicable **leverage existing community health structure**. CHVS have been repeatedly trained in RH/FP and HIV and portend a ready force of facilitators who can be rapidly deployed for DPP intervention(s)

The Unknowns

- This exercise did not delve into **assessing cost and cost-effectiveness** of highlighted interventions – need to conduct further analysis to inform this
- Do not have clarity on what **reasonable investment for demand creation** would be – costing exercise required to determine level of investment required

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