



National MNCH Programme
Ministry of Health
Government of Pakistan

**National Maternal,
Newborn and Child Health (MNCH)
Communication Strategy
Framework for Pakistan**

**National Maternal, Newborn and Child
Health Program Communication Strategy
Framework for Pakistan**

**National Maternal, Newborn and Child Health
Program, Ministry of Health,
Government of Pakistan**

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LIST OF ACRONYMS

AAA	Arjumand and Associates	LMI	Logistics Management International
AASA	Anjum Asim Shahid Associates	MMR	Maternal Mortality Ratio
ADB	Asian Development Bank	MHC	Male Health Committee
AKU	Aga Khan University	MNCH	Maternal, Neonatal and Child Health
ANC	Antenatal Care	MNT	Maternal and Neonatal Tetanus
ARI	Acute Respiratory Infection	MO	Medical Officer
BCC	Behavior Change Communication	MoH	Ministry of Health
BCP	Basic Communication Package	MoPW	Ministry of Population Welfare
BHU	Basic Health Unit	MSH	Management Sciences for Health
BP/CR	Birth Preparedness/Complications Readiness	NGO	Non Governmental Organization
CDD	Control of Diarrheal Diseases	NIPS	National Institute of Population Studies
CAM	Communication, Advocacy and Mobilization	NMR	Neonatal Mortality Rate
CAP	Community Action Process	NP for FP/PHC	National Program for Family Planning and Primary Health Care
CBA	Child Bearing Age (15-44 years)	NPPI	Norway-Pakistan Partnership Initiative
CCP	Johns Hopkins University Center for Communication Programs	RHC	Rural Health Center
CIDA	Canadian International Development Agency	RSPN	Rural Support Programme Network
CMO	Community Mobilization Officer	PAIMAN	Pakistan Initiative for Mothers and Newborns
CMW	Community Midwife	PAVHNA	Pakistan Voluntary Health and Nutrition Association
CPR	Contraceptive Prevalence Rate	PGR	Population Growth Rate
DFID	Department for International Development of UK	PDHS	Pakistan Demographic and Health Survey
DOH	Department of Health	PHC	Primary Health Care
EmONC	Emergency Obstetric and Neonatal Care	PNC	Postnatal Care
EPI	Expanded Program on Immunization	PRIDE	Primary Health Care Revitalization, Integration and Decentralization in Earthquake-affected Areas
FALAH	Family Advancement for Life and Health	PRSP	Poverty Reduction Strategy Paper
FP	Family Planning	SBA	Skilled Birth Attendant
GAVI	Global Alliance for Vaccines and Immunization	SIAs	Supplementary Immunization Activities
GoP	Government of Pakistan	SNL	Saving Newborn Lives
GP	General Practitioner	TB	Tuberculosis
HANDS	Health, Nutrition and Development Society	TBA	Traditional Birth Attendant
HC	Health Committee	TFR	Total Fertility Rate
HCP	Health Care Provider	THQ	Tehsil Headquarter Hospital
IEC	Information, Education and Communication	TT	Tetanus Toxoid
IMCI	Integrated Management of Childhood Illnesses	UNFPA	United Nations Population Fund
IMR	Infant Mortality Rate	UNICEF	United Nations Children's Fund
IRC	International Rescue Committee	USAID	United States Agency for International Development
IPC	Interpersonal Communication	WHO	World Health Organization
JICA	Japanese International Cooperation Agency	WHP	Women's Health Project
JSI	John Snow International	WMO	Woman Medical Officer
KAP	Knowledge, Attitudes and Practices	WSG	Women's Support Groups
LBW	Low Birth Weight		
LHW	Lady Health Worker		
LHV	Lady Health Visitor		

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Dr Zahid Larik
National Programme Manager
MNCHP

PREFACE

Pakistan's maternal, infant and newborn mortality rates are high despite an extensive health network. In the past decade, the Government has addressed gaps in progress by prioritizing maternal, neonatal and child health (MNCH): in supporting and expanding the Lady Health Worker (LHW) Program of nearly 100,000 community-based primary care workers; by training a new cadre of community-based midwives to address the need of skilled birth attendance; and by creating the National Maternal, Newborn and Child Health Program, a separate entity within the Pakistan Ministry of Health (MoH) to build a national coherent, innovative, cost-effective and sustainable strategy. Similarly, a number of international and bilateral agencies, as well as nongovernmental organizations (NGOs) have begun investing substantial funds to expand the access and quality of MNCH services in order to achieve more accelerated progress toward the Millennium Development Goals (MDGs). Gains in reducing child mortality and improving maternal health (Goals 4 and 5) have been slow.

Background to Providing MNCH Services

Prior to 2005, the GoP provided MNCH services through both its Ministry of Health and its Ministry of Population Welfare, with their respective health departments.¹ Services were also delivered by other separate vertical programs that focused narrowly on immunization, malaria, tuberculosis (TB) and/or HIV/AIDS or through projects, such as the Women's Health Project, Reproductive Health Project and/or National Nutrition Project. However, none of these programs or projects provided comprehensive MNCH services. The program that most encompassed MNCH services—the National Program for Family Planning and Primary Health Care (also known as Lady Health Worker Program)—was focused mainly on health education at the time and did not involve a great deal of product or service delivery.

In October 2005, with the consensus of several important stakeholders in Pakistan, a National Maternal and Child Health Policy and Strategic Framework (2005-2015) was developed, which envisioned a country where women and children were healthy and no family would lose a mother or child due to preventable or treatable causes. To provide coordination and direction, the National MNCH Program was launched. Other bilateral projects have also started in the last few years, such as the USAID-funded Pakistan Initiative for Mothers and Newborns (PAIMAN) and Family Advancement for Life and Health (FALAH) project, Save the Children's Saving Newborn Lives (SNL) Initiative, along with those of UN agencies, principally UNICEF, the UN Population Fund (UNFPA) and the World Health Organization (WHO).

Purpose and Scope of a Coordinated National MNCH Communication Strategy

The evidence generated to date indicates that communities have a very low level of awareness about MNCH. And society's prescribed gender roles largely render women powerless to make decisions about seeking MNCH services. Other socially, culturally and religiously driven beliefs and choices impede better MNCH outcomes and may exacerbate adverse results. Economic, informational and logistical obstacles further restrict households and communities from health-seeking behaviors. In recognition of these factors, the National MNCH Policy established the need for all the disparate programs and projects to address the knowledge, attitudes and behaviors of individuals and to focus on communication for behavior change.

The drive to incorporate communication as a part of MNCH services has been challenging. Many bilateral projects have already considered these components; yet they are usually narrow in scope due to their distinct programmatic focus. And even though the National MNCH Program and other MoH programs have earmarked funds for communication purposes, lack of staff expertise, evidence-based guidelines and strategic direction have hindered progress in this area. The MoH has embraced the need for comprehensive advertising, marketing, promotional and outreach strategies to increase demand for and utilization of more health services at the household and community level, and subsequent adoption of healthier practices. But Government decision makers also recognize that

¹ The following sections are derived from 2008 Save the Children MNCH Communications Strategy Workshop Report and unpublished notes shared with HDI.

an uncoordinated communication approach would result in unnecessary duplication, distortion or confusion and sub-optimal use of resources.

A consensus emerged around the need for a National MNCH Communication Strategy to synthesize the findings, lessons and approaches already in existence into an actionable document with broad guidelines. This Strategy, to be the responsibility of the National MNCH Program, is intended to bring the behavior change communication (BCC) efforts of all the key partners together under “the same umbrella.” It will guide the design, implementation and monitoring and evaluation of future plans and activities to assure a unified and uniform approach, while taking into account the needs of all stakeholders working in a variety of settings throughout the country. With the latest 2006-07 *Pakistan Demographic and Health Survey*, as well as other recently released research studies, a detailed quantitative and qualitative picture of MNCH is emerging, as well as key insights into women’s knowledge of, attitudes towards and practices related to pregnancy, childbirth, antenatal and postpartum care.

A critical and dangerous health situation necessitates a dramatic response. It requires promoting primary health services—such as mother and child immunization, clean delivery practices, emergency obstetric care and antenatal and postnatal care—while increasing awareness, acceptance and demand for these health-seeking practices. It espouses an approach where health products—such as services, providers and facilities—are developed or improved, packaged and branded to attract and satisfy the consumers. Unlike traditional BCC where results are slow and hard to measure, the approach adopted herein combines proven marketing strategies with behavioral and social sciences principles for behavior change, where communication efforts are directly measured against uptake of products and services.

Methodology

This Communication Strategy Framework has been developed through consensus building among key stakeholders. The preparation of this document has been preceded by a number of significant activities. The first step was the formation of a Core Group of ten public and private sector members to guide the development of an MNCH BCC strategy (see Annex A). During two workshops, the Core Group identified the fifteen key messages that reflect consensus on evidence-based knowledge and most appropriate interventions required to address MNCH in Pakistan (see Annex B). This Core Group decided that a National MNCH Communication Strategy was needed and that the National MNCH Program would be the lead agency. The Group requested that Save the Children provide technical assistance on communication-related issues.

Next, Save the Children hired the international marketing and communications firm Howard Delafield International (HDI) to develop the Strategy. HDI conducted a comprehensive desk review of the existing MNCH BCC strategies and materials in Pakistan to identify gaps and opportunities. The review material included planning documents from the National MNCH and LHW Programs, formative research studies, demographic and health surveys, program and project evaluations and available communication strategies.

Finally, a three-day workshop was held in Dubai in October 2008 for a group representing the major MNCH stakeholders in Pakistan, both BCC officers and national and provincial program managers². The National MNCH Program extended invitations for fifteen participants from among its staff and local international partners. The purpose was to arrive at a consensus on elements of the national strategy: key target audiences (who); desired behavioral responses (what); key benefits for behavior change (why); initial creative approaches (how) and potential media channels including community-based interventions (where); implementation roles (by whom); and next steps. The workshop participants are in Annex C.

The draft strategy document will be reviewed by a group in Pakistan, and the final strategy with incorporated comments will acknowledge the contribution of the reviewers.

² The workshop was held in Dubai because HDI staff could not get visas to Pakistan and the security situation in the country at the time was a concern.

Document Sections

The document is divided into two parts:

Part One contains the Situational Analysis based on planning documents, evaluations, annual reports and communications plans, activities and strategies from Government, multilateral, bilateral, nongovernmental, and private sector sources. The very latest data has been cited from the 2006-07 *Pakistan Demographic and Health Survey*. In the first section a brief of the major players and programs for MNCH and a description of the existing well-developed communication strategies have been placed in the main body to give a contextual snapshot. An inventory of significant players and programs has been provided as Annexure K.

Part Two provides a roadmap of sorts. It explains marketing concepts and approaches, categorizes the broad array of communications objectives, analyzes the behavioral objectives and responses of various demand- and supply-side target audiences, and presents a strategic framework with priority interventions, sample action plans and next steps.

PART ONE

SITUATIONAL ANALYSIS

Current MNCH portrait

As a direct entry point for improved social and economic development, maternal and child health has been the focus of national policies, plans and programs in Pakistan for several decades, all of which aim to provide wider access to better quality services in hopes of reversing Pakistan's poor morbidity and mortality indicators. The MDGs call for a three-quarters reduction in the maternal mortality ratio by 2015 and a two-thirds reduction in the mortality rate for children under five. However, progress on improving MNCH has been slow and remains a challenge. Pakistan has lagged behind most developing nations, including neighbors Bangladesh, India and Sri Lanka (MNCH, 2006).

The level of poverty, low literacy levels and women's low status undermine improvement efforts. And there are weaknesses in the health system, such as lack of focus on prevention, gender imbalances, human resource and management deficiencies and insufficient funds. A growing population has overburdened social and health care services in general, and due to repeated pregnancies and frequent childbirth, the health of mothers and newborns continues to be threatened.

1) Country Context

Pakistan's population has quadrupled since 1950 to a projected 168 million (by 2010) due to the high population growth rate (PGR) over the years. It is the sixth most populous country in the world, and, among those six, has the highest rate of population growth (MoPVV, 2007). About two-thirds of the population is rural (67 percent), with 89 percent of households drinking untreated water and 43 percent without proper sanitation facilities, greatly impacting household infectious disease.³

The population growth rate (PGR) has declined from a record high of 3.7 percent in the previous decades to its current level of 1.9 percent per annum. Same is the case with the total fertility rate (TFR), which has dropped to 4.1 from 5.4 in 1990-01. Pakistan's gradual shift from high to low mortality and fertility has resulted in a change in age structure. In the past five years, there has been a rising cohort of women of child bearing age (CBA), who now constitute over one quarter of the total population (nearly 26 percent), with absolute numbers having increased since 2001. On the other hand, there has been a gradual fall in the proportion of children under age 5.

Overall, 55 percent of Pakistani women have a demand for FP; yet, only just over half of the demand for contraception is being satisfied. Among currently married women, there is a still a 25 percent unmet need for FP services, of which 11 percent report a need for spacing and 14 percent a need for limiting. The current contraceptive prevalence rate (CPR) is 22 percent compared to 9 percent 15 years ago. While this achievement is commendable, a high TFR continues to expose women and children to increased risks of mortality and morbidity and is a long way from achieving the Government's overall goal of population stability.

Box 1. Maternal and Child Health Statistics

Total Fertility Rate (TFR)	4.1 births per woman
Contraceptive Prevalence Rate (CPR)	22 percent
Infant Mortality Rate (IMR)	78 (per 1,000 live births)
Neonatal Mortality Rate (NMR)	58 (per 1,000 live births)
Under-five Child Mortality Rate	94 (per 1,000 live births)
Maternal Mortality Ratio (MMR)	276 (per 100,000 live births)
Source: Pakistan Demographic and Health Survey 2006-07	

³ All data are taken from the 2008 National Institute of Population Studies (NIPS) and Macro International Pakistan Demographic and Health Survey 2006-07 unless otherwise noted.

2) Mortality Rates

The latest **maternal mortality ratio (MMR)** is 276 maternal deaths per 100,000 births, slightly lower than the generally accepted previous estimates of around 320. Among adult women of CBA, complications from pregnancy and childbirth are the leading cause of death, accounting for one-fifth of deaths to women during their reproductive period. Postpartum hemorrhage is the leading direct cause, followed by sepsis and eclampsia. Obstetric bleeding (postpartum and antepartum hemorrhage) is responsible for one-third of all maternal deaths. The data from the DHS imply that roughly 1 in 89 women in Pakistan will die of maternal health causes during her lifetime.

The **infant and under-five mortality rates** have declined steadily over the last two decades to the current rates of 78/1,000 and 94/1,000 deaths per live births respectively. Under-five mortality has declined from 117 in 1986-90, a 20 percent drop in 16 years. The infant mortality rate (IMR) has shown no appreciable change since 2003. Every day, about 590 children in Pakistan die during their first 28 days of life. An additional 500 who survive their first month die at under five years of age every day. About 420,000 children under the age of five die every year in Pakistan (UNICEF, 2007). And there has been no concomitant decline in the **neonatal mortality rate (NMR), which was recorded as 58** per 1,000 live births in the latest DHS survey. Differentials by place of residence show that the IMR is 32 percent higher in rural areas than in urban areas (55 vs. 81 deaths per 1,000 live births).

The annual number of neonatal deaths in Pakistan is close to 300,000, ranking it third behind India and China. Of the ten countries with the highest NMRs, only Afghanistan has a higher rate (60/1,000 per live births) than Pakistan. Neonatal mortality contributes from 40-60 percent of the total infant deaths annually in Pakistan. A large proportion of maternal and neonatal deaths occur during the 24 hours after delivery (Save the Children, 2008a). The first two days after delivery are also critical for monitoring birth complications. Data on the leading causes of newborn deaths identify birth asphyxia, infections and premature delivery. Together these three account for nearly 76 percent of neonatal mortality.

3) Reproductive Health Context

The majority of births (65 percent) take place at home, most often assisted by an untrained traditional birth attendant (TBA, also called *dai*) or family members. But untrained assisted deliveries cause risk for mother and child when there are birth complications, especially at night in remote areas. PAIMAN household survey research has shown that the majority of women, their families and providers do not focus on preparing and planning for the delivery of a baby, and are mostly unaware of potential pregnancy and birth-related health emergencies or post-partum complications (PAIMAN, 2008a).

Overall, less than 40 percent of births take place with the assistance of a skilled medical provider (such as doctor, nurse, trained midwife or Lady Health Visitor⁴). In Punjab, Pakistan's most heavily populated province, for instance, only 33 percent of births take place in the presence of a skilled birth attendant (SBA). In rural Punjab, this falls to 26 percent and contributes to Punjab's high MMR of 300 deaths per 100,000 live births (UNICEF, 2008b). Use of home delivery kits promotes safe and clean delivery. Nearly a third of home births used the kit.

The 2006-07 Pakistan Demographic and Health Survey polled women who had a birth in the five years preceding the survey as to why they did not deliver in a health facility. The two main reasons given are that it is unnecessary (57 percent) and that it costs too much (38 percent). Far behind those reasons are that they are not allowed to by family (9 percent) and that it is too far (8 percent). In the PAIMAN household survey, respondents indicated that they don't like to leave home to give birth and that the *dai* is an expert who is always available, less expensive and has delivered the most babies in the community (PAIMAN, 2006b).

Yet the percentage of births that do take place in a health facility has doubled in the past ten years, increasing from 17 percent in 1996 to 34 percent in 2006-07 (11 percent in a public sector facility and 23 percent in a private one).

4 A Lady Health Visitor (LHV) is a specific cadre of health care provider with one year of midwifery training who focuses on basic nursing care and maternal and child health services.

Research found that skilled health providers are more likely to attend births to mothers age 20-34 and first order births (41 percent and 54 percent, respectively). Births in urban areas are twice as likely to be assisted by a skilled health provider (60 percent) than births in rural areas (30 percent).

Box 2. Antenatal, Delivery and Postnatal Care Statistics

Women receiving antenatal care from skilled provider	61%
Women receiving postnatal care from skilled provider	43%
Births assisted by skilled provider	39%
Births delivered at health facility	34%
Fully vaccinated children (12-23m)	47%
Pregnant mothers receiving at least two TT injections	53%

Source: Pakistan Demographic and Health Survey 2006-07

4) Health-seeking MNC Practices

Studies show that women and their families are often not familiar with pre- and post-natal healthy behaviors and do not understand the benefits for the mother and fetus of such measures as maternal immunization with tetanus toxoid (TT), anemia screening, management of maternal malnutrition and identifying dangerous newborn infections. Further, men, in particular, do not prioritize antenatal care, which hinders care-seeking in general (AAA, 2008). But overall, there has been an uptake in the use and quality of antenatal care services in recent years. Some 61 percent of mothers receive some type of antenatal care from a skilled health provider, up significantly from 33 percent a decade ago. More than a quarter make four or more visits during their pregnancy. And, for example, the percentage of mothers who received at least two TT injections during pregnancy has doubled—from 29 percent in 2001 to 53 percent in 2006-07. Only 3 percent of women receive antenatal care from a TBA/dai; and 35 percent of women still do not receive any antenatal care at all.

Postnatal care is less common for women in Pakistan than antenatal care—only 43 percent seek some form of care: 27 percent from a skilled provider and 16 percent for TBA/dai. However, the majority of women (three out of five) do not get any postnatal checkup at all. The PAIMAN household surveys indicate that most women do not consider the postpartum period as part of the pregnancy cycle (PAIMAN, 2006b).

Breastfeeding in Pakistan is nearly universal and mostly of fairly long duration. Some 70 percent of newborns are breastfed within one day after delivery. Slightly more than half of children under the age of two months (55 percent) are exclusively breastfed. This represents a doubling from the 27 percent in 1990-91. Yet, only 37 percent of infants under 6 months are exclusively breastfed, far lower than the recommended 100 percent.⁵ There has been a steady upward trend in the proportion of children who are fully immunized from 35 percent in 1990-91 to 47 percent in 2006-07.

Study findings show that not all mothers realize that their diet may affect their newborn's health. There are also many misconceptions about what constitutes healthy versus unhealthy foods. Even if mothers would like to include healthier foods in their diet, they may face criticism from family members. In general, poverty prevents their regular consumption (AAA, 2008).

Malnutrition is still a widespread contributor to high morbidity and mortality. Poor nutrition contributes to about 50 percent of all under-five deaths. National Nutrition Surveys conducted in 1985-1987 and 2001-2002 show that Pakistan has made slow progress in reducing moderately or severely underweight children. Some 17 percent of lactating mothers are malnourished and one third of under-five children are anemic (UNICEF, 2007).

⁵ Note: UNICEF's *Pakistan Annual Report 2007* quotes a figure of only 16 percent of infants under six months being exclusively breastfed.

5) Healthcare Service Providers

Pakistan has an extensive health service network of public sector facilities, though they reach only about one third of the population. For preventative services and for isolated rural communities, public health facilities are the most vital service provider; yet Basic Health Units (BHU) are seriously underutilized due to lack of confidence in quality of care, lack of trust in staff due to frequent turnover, inadequate services, and lack of available personnel and medicines once a client gets to a facility (PAIMAN, 2006b). Maintaining the existing ratio of population per public health facility is very challenging due to population increases, lack of funding and the state of disrepair of facilities (MNCH, 2006).

Table 1. Public Health Facilities and Staffing Nationwide

Public Facility/Provider	Number of Facilities/ Providers
Public Hospital	946
Rural Health Center	552
Basic Health Unit	5,290
MNCH Center	--
General Physicians	100,131
Nurses	27,677
Lady Health Visitors (LHV)	6,741

Source: MNCH, 2006.

The remaining 70 percent of people are served by the fragmented fee-for-service private sector, mainly for curative services (MNCH, 2006). Providers and clients alike agree that improvements need to be made in physical facilities, supply streams, equipment and provider capabilities and availability. More female staff are needed, and women's privacy needs to be considered (PAIMAN, 2008a). And the Ministry of Health (MoH) acknowledges that it must improve district health management, develop feasible standards and guidelines for service delivery, address gender imbalances, focus on preventative interventions and improve quality of care at different levels of the system (MNCH, 2006).

At the community level, an obstetric emergency can not be handled and precious time is wasted in contacting skilled providers or reaching out to appropriate health facilities. But a PAIMAN assessment found that within the 10 districts where it operates, basic Emergency Obstetric and Neonatal Care (EmONC) services were only available in 23 percent of RHCs and comprehensive EmONC services were only available in 20 percent of Tehsil Headquarter Hospitals (THQs). In all types of health facilities, the ratio of male to female doctors was 3.5 to 1 (PAIMAN, 2008b).

The GoP has a long-term strategy to have an Skilled Birth Attendant (SBA)—such as a LHV—available to each mother and newborn both in health facilities and a community midwife at the household level; but, in the short-term, solutions are being built around better use of existing rural health care providers, particularly, Lady Health Workers and the TBAs with a need to strengthen links between them (*discussed in next chapter*).

6) Nutrition

Pakistan has a very high burden of malnutrition (both stunting and wasting). The absolute number of stunted children under 5 years of age rose from 7037100 in 1992 to 8765670 in 2002 (25% increase), similarly number of wasted children under five years of age rose from 2848350 in 1992 to 3079830 in 2002 (9% increase). There is inadequate practice of both early initiation and exclusive breastfeeding. The recent data from the PDHS 2006/7 shows only 37% of infants aged 0-5 months are exclusively breastfed. Over the period, there has been little improvement in exclusive breastfeeding rate (only 12% over 15 years) in Pakistan. Only about one thirds of infants receive complementary food on appropriate time, and there has been no improvement over the period (PDHS 1990 to PDHS 2006/2007). According to the Complementary Feeding Study conducted by AKU in 2007, a

large percentage of infants are given complementary food before 5 months, and smaller percentage of infants is given too late, after 9 months. Continued breastfeeding practices are also not optimal, less than half of the children aged 18 -24 months are breastfed.

Major Players and Programs

The major players and programs working for MNCH in Pakistan are enlisted here with the details provided in Annexure K.

1) Key Ministry Programs

- a) National Programme For Family Planning and Primary Health Care also known as LHWP
- b) National Maternal, Newborn and Child Health Program

2) Other Programs

- a) Ministry of Population Welfare
- b) Women's Health Project
- c) National Nutrition Program
- d) National Expanded program on Immunization
- e) Polio Eradication Initiative
- f) Integrated management of Childhood Illness (IMCI) Strategy
- g) Acute Respiratory Infections (ARI) Control project
- h) Reproductive Health Project

3) Partnership with United Nations

- a) WHO
- b) UNICEF
- c) UNFPA

4) Donor funded Projects

- a) Pakistan Initiative for Mothers and Newborns (PAIMAN)
- b) Family Advancement for Life and Health (FALAH)
- c) Primary Health Care Revitalization, Integration and Decentralization in Earthquake Affected Areas
- d) Pakistan Health Systems Strengthening Project now known as Technical Assistance for Capacity Building in Midwifery, Information and Logistics (TACMIL)
- e) Norway Pakistan Partnership Initiative (NPPI)
- f) Research and Advocacy Fund (RAF)

5) Partnership with NGOs

- a) Save the Children's Saving Newborn Lives SNL-2
- b) Maintaining Tetanus Elimination Status in Pakistan

Spotlight on Major Communication, Advocacy and Mobilization (CAM) Strategies

The following section describes well-researched and discussed MNCH-related communication strategies that have been consulted to arrive at the National MNCH Communication Strategy Framework. They come from the following:

- National Program for FP and PHC (the Lady Health Worker Program)
- Pakistan Initiative for Mothers and Newborns (PAIMAN)⁶
- Family Advancement for Life and Health (FALAH) Project
- Save the Children's Maintaining Tetanus Elimination Program
- Community Action Process (CAP) in Kalat by UNICEF
- Mother and Child health Week by UNICEF

The common principles that provide the foundation for all the strategic communication thinking are listed up front so as not to duplicate their mention repeatedly. Next, general approaches and unique facets from the four communication strategies are highlighted.

I) Background

a) Underlying Principles

These common principles cut across all four CAM strategies as detailed below:

- **Broad view of change.** Decision making and behavior change involve not only the caregiver and the concerned individual, but the whole family, and sometimes the whole community.
- **Men's decision-making roles.** The traditional low status of women and their lack of power is central to all the communication work, which invariably includes men as a major audience.
- **Science- and research-based.** Baseline studies, formative research and field assessments have to be conducted to improve understanding of the needs of target populations.
- **Balanced supply and demand.** Creating demand that cannot be fulfilled because the health system is not prepared frustrates the people seeking services and overwhelms staff, which may cause rejection and reversal of behaviors.
- **Consumer-centered and benefit-oriented.** Planners need to learn how to create rapport with the target audiences and describe the health problems affecting them from the audiences' perspectives, which may not place health or even fear of death as a priority, but rather address lifestyle benefits that are more likely to engender behavior change. Messages should motivate a "response" and not just create awareness.
- **Results-oriented and service-linked.** The communication is programmatically sustainable and not something that is done once.
- **Reinforce existing structures.** Key partnerships are selected so that interventions maximize the benefits of existing experience with available resources and community infrastructure.
- **Multi-channeled.** Each channel has a role to play and communicators should use the tool or combination that is most appropriate to situation according to reach, frequency and cost-effectiveness for scale-up.

6 PAIMAN's BCC component synchronizes with the key features and strategies of the communication component of the 2006 National MNCH Program Planning Commission (PC-1) document to maintain consistency of messages.

b) Communication Strategies and Materials Already Available

Most of the aforementioned programs outlined in the last section have valuable BCC, CAM and IPC training components that should be taken in account. In addition to those listed, the following past projects have produced materials as well:

- Asia Foundation and USAID's Balochistan Motherhood Initiative (BSMI);
- Population Council's Safe Motherhood Applied Research and Training (SMART);
- Population Council's Salutation Assessment Help & Reassurance Training (SAHR);
- USAID/CATALYST's Optimal Birth Spacing Project.

Source: Save the Children, 2005a.

2) Key CAM Strategies and Interventions

The formulation of the National MNCH Communication Strategy Framework has been guided by a research and consensus-building process, centered around the following four major existing communication strategies:

a) BCC Strategy of the National Program for FP and PHC (LHW Program)

The BCC Strategy was developed in mid-2005 to provide the necessary strategic framework for purposeful national and international BCC partnerships and to bring synergy to the different BCC interventions being undertaken by different agencies. Much of what is discussed in the strategy has been or is being implemented.

It proposes to strengthen the role of the LHW in providing behavioral messages and communication that empower people to become active participants in their own health. To best accomplish this, BCC interventions should be integrated at the levels of the preventive, promotive, curative and rehabilitative services already being provided by the LHW. It also advocates for community-level workers, including the male and female village health committees (HCs) to serve as counterparts in providing the communication services.

Strategic Framework

The framework includes the following as well as advocacy (*covered separately later on*):

Social Mobilization

- Health Education Officers and the District Coordinators trained to conduct sensitization and other activities for decision makers and policymakers at the district and union council levels, such as opinion leaders, NGOs, professional and religious groups, local media, and the private sector;
- National Program District Coordinators who plan and incorporate communication interventions within the existing work-plans;
- An operational field guide with concepts and methods of organizing and conducting advocacy and social mobilization to be developed for district teams.

Community Mobilization

- The network of volunteers trained, equipped and involved in expansion and promotion of the health messages;
- Through this process, members of the community become organized and involved in project planning and implementation at local levels and in monitoring and evaluation.

Institutional Mobilization and Health Education

- All the providers within the health delivery system, whether they are traditional healers or other home-based care providers, enhance their skills and are equipped with appropriate knowledge for providing PHC services as counterparts to the LHWs;
- Behavioral component that addresses issues such as attitudes, management styles and task organization, in order to enhance the quality of services.

Health Promotion

- LHW's communication and counseling skills strengthened through providing a more structured design- and objective-oriented visit plan by equipping them and their counterparts with the required IEC materials;
- Minimum standards criterion for BCC services developed as job-aids for different cadres of BCC providers at all levels;
- BCC curriculum developed at the national level for different cadres of staff;
- A communication resource center to be established with the help of partner agencies that will conduct research, build communication tools, develop training curriculums and document and disseminate data on a regular basis.

Main Features

In addition to approaching campaigns according to above mentioned general underlying principles, some other specific strategies were put forward:

Creation of Basic Communication Package (BCP)

The BCP is a complete package that outlines the major behaviors and their subset of behaviors to be implemented universally at all areas of interventions and in collaboration with all parallel programs. The package contains communication plans, skills sets, field guides and include IEC material for all levels of strategic implementation adapted from the programs that are already implementing specific packages, e.g., TB, Malaria, HIV/AIDS, MNH, FP, child care, immunization, etc. The package is to be adopted by partner agencies for implementing BCC within their program areas as a whole and not in parts. A series of "creative design development workshops" would be held with all levels of stakeholders and partners to agree on materials development, printing and distribution; national training modules design; and implementation.

Gender Perspective to Messaging

MDG-3 focuses on promoting gender equality. Health communication that fosters the mother's health within a holistic family perspective would highlight women's changing roles and responsibilities along with addressing her health needs. The first part of the message emphasizes the "role of mother in nurturing a healthy family" and the "importance of her adopting healthy behaviors in caring for the family." The second part focuses on "the role of father/male involvement" in making healthy choices for the family.

Synergized Mass Media Campaigns

The campaigns will be branded and coordinated with the community mobilization process. Efforts should be made to coordinate the mass media campaigns with communication activities at other levels. Information and media plans are to be shared and trickled down to the LHW level so that she can refer to and translate the media messages during her interpersonal sessions.

Public-Private Partnerships

Gaining support and making the private sector part of the communication agenda is vital since so many people are served by private providers. And companies are often willing partners in health. Resources can be mobilized by partnering with those that manufacture health-related items like soap, mosquito coils, etc. The idea is to integrate a health message within their marketing and social services plans.

The LHW Program, which is widely recognized as one of the MoH's most successful programs has the potential to help integrate MNHC services being delivered at the community level through existing infrastructure. With the LHWs playing a significant role in immunization coverage (EPI), case detection and follow-up of TB cases, initial referral and treatment of suspected malaria cases (Roll Back Malaria Program) and providing nutritional education and supplies (Nutrition Program) and a key role in monitoring immediate newborn care, they are a critical asset.

The National MNCH Program will have to work closely with the well-established LHW Program going forward. And partnerships at all levels, especially with agencies, programs and projects that have strong networks and infrastructure at the community level should be sought out so that they

can be utilized as counterparts for duplicating and replicating the LHW's BCC tasks. The type of communication services will have to be developed through a team approach instead of loading up the LHWs with different interventions and for each health problem.

Source: NP for FP&PHC, 2005.

b) Pakistan Initiative for Mothers and Newborns (PAIMAN) CAM Strategy⁷

Strategic communication about MNH has gradually shifted away from a mother-centered approach of risk management to a more generalized approach that involves the family and community. This is because family and community members' views often have more sway than those of the pregnant woman, particularly in an obstetric emergency.

The PAIMAN qualitative study revealed that most women, their husbands and other family members showed total dependence on HCPs for pregnancy and delivery. To them, these providers (mostly TBAs) were the sole source of information and health education. HCPs, though, did not see providing health education as their responsibility. This highlighted the critical importance of communication activities. The challenge is to ensure universal skilled healthcare for women and newborns throughout pregnancy, childbirth and the postpartum period, while also increasing awareness broadly among communities.

The future goal of universal skilled attendance with CMWs will be successful only if there is a strong BCC strategy in place, which creates awareness, mobilizes the community and establishes links with TBAs and LHWs and ultimately with fully functional health facilities.

Strategy Development

The CAM Strategy was informed by an extensive literature review, a baseline survey and the results from two in-depth formative research studies (*discussed previously*).⁸ In order to develop effective health communication messages and BCC interventions at the national and local level, the studies probed the existing knowledge, practices and norms of married women, husbands and family members related to MNH birth preparedness and complication readiness behaviors.

Main Features

In this strategy, community mobilization is the mainstay of behavior change. Advocacy will help garner national support for the program as well as ensure functioning facilities. Communication activities challenge current thinking and behaviors by creating awareness of the problem and suggesting actions to change the milieu.

The PAIMAN CAM activities occur at several levels:

- **National level:** the focus is on improving advocacy efforts to create a more favorable environment. In addition, mass media activities are conducted for the general public to increase awareness of the MNH issues.
- **Provincial level:** the focus is on advocating for more resources for communication activities focus on enhancing capacity of Health Education Managers.
- **District level:** the focus is to build CAM capacity of the government and NGO partners. Districts are to develop specific CAM strategies using the baseline and formative research results.
- **Local level:** the focus is on community mobilization activities to encourage communities to take necessary actions to save mothers and newborns.

Despite the strategy being primarily focused on the 10 PAIMAN districts, they are extremely diverse and capture the diversity of the whole country. PAIMAN districts have varied profiles in communication access, health indicators, gender roles and health KAPs. Families may have good media access and access to LHWs in one community and not another. In its District Communication Action Plans, PAIMAN has been careful about selecting communication channels that are available and appropriate. For example, the

⁷ As pointed out earlier, PAIMAN's BCC component synchronizes with the key features and strategies of the communication component of the 2006 National MINCH Program Planning Commission (PC-1) document to maintain consistency of messages.

⁸ PAIMAN contracted Arjumand and Associates (AAA) to carry out this study from September 2005 to May 2006 in seven districts, 3 in Punjab (DG Khan, Khanewal and Rawalpindi), 2 in Sindh (Dadu and Sukkur) and 1 each in Balochistan (Jaffarabad) and North West Frontier Province (Buner).

channel of religious scholars and *Hujra* (traditional community center) meetings is used more in the relatively conservative districts.

Valuable Resources

PAIMAN has produced a wealth of material, including the following, which are contained within the strategy document:

- **Extensive Message Matrix:** built upon formative research findings;
- **Community Mobilization Tools and Approaches:** a guide based on communities whose RHC received upgrades;
- **Model District Communication Action Plan:** example from Buner District.

Source: PAIMAN, 2008a.

c) Family Advancement for Life and Health (FALAH) CAM Strategy (in draft)

The primary focus of this draft strategy is to increase the understanding by married couples of the benefits of birth spacing. It is intended to support, and to assist in implementation of, the *Communications and Advocacy Strategy 2008-2013* of the MoPW's Population Welfare Program, which includes an emphasis on birth spacing, reproductive health, community mobilization, advocacy, male involvement, breast feeding, the value of the girl child, and telling the truth about myths that surround contraception in Pakistan.

To ensure a unified approach, FALAH will work with the MoPW's Behavior Change Committee (BCC), MOH, provincial governments and district governments to strengthen their capacities to design, implement, and monitor the BCC campaign. FALAH's communication campaigns will, to the maximum extent possible, complement and develop synergies with all other government and private sector FP and birth spacing communication activities.

Evaluation of Past Programs

Population programs in Pakistan since early days have had communication campaigns as an essential component to boost service delivery efforts. The past IEC campaigns relied heavily on mass media for creating awareness and focused on increased visibility of the program. People were made aware of the FP choices through field workers. These efforts have led to increased awareness regarding FP methods to almost universal levels, a remarkable achievement. However, gaps between awareness and practice remain high.

With the partial exception of the social marketing organizations, there have been few attempts to implement coordinated FP communication campaigns through mass media, community media, and interpersonal communication.

The main focus of communication programs has also been on the urban population, which neglects the information needs of rural people who make up two-thirds of the population. Accordingly, the MoPW's 2008-2013 strategy recognizes that the rural population should be the prime focus of communication strategies.

There is also paucity of timely baseline, monitoring and impact evaluation studies of FP/RH programs, which allow teams to make adjustments in program activities. There is a need to make extra efforts regarding research and evaluation to validate communications strategies. A continuous forum of researching and learning about the effectiveness of the interventions will be established that will track the interventions and provide evidence and rationales for continuity, non-continuity or modification.

Current FP and Birth Spacing Communication

Communication support for FP is provided primarily by the major service providers. The MoPW, MoH (through LHWs) and Greenstar Social Marketing (GSM) all provide substantial mass media support. The PAIMAN project has been implementing their CAM strategy in eight of FALAH's districts. All service providers are expected to provide interpersonal communication (IPC), although their training and skills for this vary. The MoPW has more than 4,000 Male Motivators in rural areas to reach men.

But by far the largest program for community mobilization is implemented through the LHWs. The FALAH project plans to capitalize on existing networks to address major types of audiences (married couples, providers, and influencers, each with multiple sub-audiences).

Main Features

Focus on birth spacing message. This strategy aims to re-position family planning by focusing primarily on the health benefits of birth spacing and away from fertility limitation with a single message: *birth spacing is beneficial for MCH*. This is intended to legitimize the topic among all necessary components of the population, e.g., Government ministries, elites, religious leaders, and the general public.

Primacy of interpersonal communication. The primary focus of IP within FALAH will be on reaching married couples and influencers through interpersonal communication, both through social mobilization activities and through providers. The Male Motivator system will be strengthened, and IP will be backed by community and mass media.

Source: Population Council, 2008c and 2008d.

d) Save the Children's Maintaining Tetanus Elimination CAM Strategy (in draft)

Maintaining tetanus elimination requires a comprehensive approach that encompasses service delivery and necessary education, motivation and awareness support as a package. Effective use of social mobilization precedes service delivery efforts to ensure its success and create an enabling environment for people to understand the importance and maintain a demand for the services.

In addition to immunization of pregnant women against tetanus, sustainability of MNT elimination depends on a number of other closely related factors, i.e., antenatal care, skilled birth attendance and safe and clean delivery practices. In the short run, the strategy aims to raise knowledge and awareness to increase demand for antenatal care that includes the TT2 vaccination. In the long-run, the strategy aims to change behaviors for using clean and safe delivery practices, especially those that relate to umbilical cord care. Ultimately, the goal is *universal acceptability and demand for routine vaccination of children and of pregnant women*.

Existing Communication Strategies

The National Expanded Program on Immunization (EPI) mandates a focus on vaccinations only. Sizeable EPI communications activities focus on polio eradication. In contrast, the LHW Program supports broad provision of necessary education, awareness and linkage to services. The agreed new role of LHWs makes them responsible for administering all vaccines (except BCG) to all women and children in the target group. The vaccinations will preferably be given in an EPI fixed center on a fixed day every week.

Although, the EPI refers to the promotion of routine immunization through health education and communications, no solid EPI activity plan is on the table to strengthen the *routine* immunization process, especially addressing misconceptions and increased refusal rate in regions of NWFP. The EPI Communication Plan could be modified to enhance social acceptance of routine immunization by involving religious, social and civic partners in immunization activities at all levels.

A future goal for the National Program for FP and PHC could be to develop a strategy that engulfs all vaccinations (including TT vaccinations) and allows the LHWs to focus more on encouraging and educating mothers for safe delivery and cord care.

Source: Ahmed & Ikram, 2008.

Saving Newborn Lives' CAM Contributions

Saving Newborn Lives (SNL) -I has produced a great deal of material that has been adopted and well utilized by the GoP:

- The National Program for FP and PHC adapted some of the SNL BCC materials for use in their national LHW curriculum. Materials were also adapted for use by LHWs during counseling and health education sessions.
- Production and distribution of the key IEC materials used by LHWs has been built into the Government's own budgetary commitments and materials have been adapted.
- SNL's advocacy efforts also reached rural communities where events like district level advocacy seminars were well received by the local rural population, including local authorities like *nazims*, counselors and village heads, and could be replicated.

The final evaluation of SNL-I had numerous recommendations about BCC activities, as follows:

Scale up WSGs and MHCs (see box below)

- Male health committees (MHCs) and women support groups (WSGs) were effective in creating an enabling environment and venue for information-sharing in a culturally appropriate context linked to local health care facilities and community-level workers. The WSG and MHC model appears to have made great strides in a short time. Document and assess the model (e.g., *how long does it take to form, support needed at different phases, criteria for exit of support/graduation*) in order to develop a scale-up and sustainability strategy. Include mechanisms for continuing to recognize the efforts of the LHWs and MHCs, and for involving mothers-in-law and TBAs in support groups in instances where they don't already attend (see box below).
- Most MHCs have developed a collaborative way of working with the LHWs; men have greatly appreciated being involved in the process and are now more likely to believe that pregnancy is not exclusively a women's issue.
- The WSGs seem to be functioning well in terms of information dissemination. Women feel they have a better understanding of MNH information received through the safe and friendly WSG as compared to individual counseling.
- Save the Children/P is utilizing similar support group methodologies under the USAID-funded Social Marketing Project with Population Services International (PSI), which presents an opportunity to further strengthen, refine and sustain this type of model for the future.

TBA and LHW Linkages

- Continue to build linkages between TBAs and LHWs, largely based on role clarification. It contributed to positive changes in clean delivery practices and postnatal maternal and newborn checkups. Revise the LHW training and increase it to 7 days (4 days classroom/3 days in the field) in order to provide adequate hands-on experience in working in the community.
- Assist MoH to develop an appropriate supervision/monitoring system for TBAs.
- Simplify TBA registers to include a limited number of essential indicators, and investigate the use of a pictorial form.

Materials

- Assess whether LHWs in other WHP districts who received BCC materials are using them and, if so, if they are using them appropriately. Monitor the re-supply of BCC materials to LHWs (e.g., *Family Booklets, Delivery Checklist, Bachat Banks*) and support gaps by helping to identify additional funding sources, preferably more sustainable than SNL/P.
- SNL/P funded production of high-quality BCC/IEC and training materials, videos, and counseling aids as well as BCC Consultant Teams to work with community groups and LHWs. While these program components were considered critical to the achievement of objectives, they were funded through SNL/P and may not be sustainable within the government's own budgetary commitments.
- Translate training materials and job aids into local languages when required.
- In the future, consider a reduced number of simple, actionable messages based on prioritized resistant behaviors. Both the LHWs and women find counseling cards very useful. And the delivery checklist seemed to be a good reminder for families on clean delivery practices and delayed bathing.

Source: Save the Children, 2005b.

Box3. Establishing Support Groups to Help LHWs

Since a LHW is expected to focus on about 160 married women of CBA and reach the rest of the population too, Save the Children, US has been providing technical support in building the LHWs' communication skills (individual and group counseling) and in forming and reorganizing women's support groups (WSG) and male health committees (MHC) to help diffuse information.

At least 60 trainers (including Medical Officers, Women Medical Officers, Lady Health Supervisors, Female Medical Technicians, Lady Health Visitors and dispensers) from each district would be trained in counseling skills and support group methodology, who would further trickle down training to the RHF or BHU level and to LHWs. Trained LHWs, in turn will be responsible to conduct WSGs and reorganize MHCs in their respective areas. For this purpose IEC material is provided at all levels.

According to the methodology a WSG has 10-15 participants, and an LHW needs to organize at least 10-12 of them to cover her area, meeting at regular intervals, with participation of mothers, mother-in-laws, newly wed females and unmarried women to cover her area. An MHC should comprise about five males, identified by the LHW, who meet monthly and are willing to work voluntarily and report to her. Ideally, they should represent different community interest groups.

Expected Outcomes

- Regular flow of information regarding essential MNH care practices in the community, especially clean delivery practices;
- Establishment/strengthening of linkages between community and health care providers and a liaison member;
- Early decision-making for referrals in case of maternal or newborn danger signs;
- Establishment of revolving emergency funds for mothers and newborns and an emergency transport system.

Source: Save the Children, 2008b.

e) Community Action Process (CAP) in Kalat, by UNICEF

In 2004, UNICEF initiated Child Survival and Development through CAP in Kalat District of Balochistan Province. It focused on the capacity building of individuals, families and community from local government to the provincial level to address the critical problems affecting the well being of children. There were four major aspects of the CAP:

- **Integrated Approach-** Families, caregivers, community as well as religious leaders, NGOs and local government officials involvement .
- **Low Investment Strategy-**Financial inputs from UNICEF limited to training and capacity building.
- **Self Sustaining and Self Propogating-**Using Triple A Cycle community members assess a situation, analyse its causes and determine what actions should be taken.
- **Development from within communities-**Members of the community identify and discuss problems through lens of child survival development and find solutions from their own resources.

Measureable Achievements:

- Household consumption of iodized salt increased from under 5% to over 70% in 2 clusters and from negligible to to nearly 25% in one.
- High birth registration.
- Vaccination rate increased to 100% in target villages.
- Improved sanitation.
- HH level data collection improved.

Less Measurebale Achievements:

The CAP resulted into creation of networks among and between communities of the district. There was an enhanced involvement of young people and children and also a cadre of trained young men and women was formed. The public was more sensitized on well being of women and children. There was an increased opportunity of communication and working with local government.

The project concluded that the issues of child survival and development in remote and underserved areas can be addressed through CAP. It offers a low cost sustainable method which is easily replicable and adaptable in other areas. However strong monitoring and sufficient services delivery back up is imperative to its success.

f) Mother and Child Health Week, by NP for FP and PHC

National Programme for Family Planning and Primary Health Care, Ministry of Health in collaboration with ministries of environment and population welfare, National Programmes on EPI, Maternal, Newborn and Child Health; UNICEF, Rural Support Programme Network, Plan International, PAIMAN, and PRIDE conducts a **Mother & Child Week**. This is one of the key initiatives by Ministry of Health, this year in 29 districts and 5 IDP camps in NWFP with focused awareness and service delivery on Maternal, New born and Child Health Care. Initially the Mother & Child Week was piloted in 6 districts in all provinces in 2008 with a focus on prevention of diarrhoea in April and prevention and management of Pneumonia in October with excellent results and hence scaled up to 29 districts in 2009.

A pre and post survey assessment of April 2008 showed that

- Children (0-23 months) starting immunization (BCG coverage) increased from 79% to 88%
- Pregnant women who had received first dose of TT increased from 33% to 67%
- Children (2-5 years) who had received de-worming tablet increased from 24% to 87%
- Percent mothers who could tell correctly about what is meant by exclusive breast feeding increased from 57% to 78%
- Percent mothers who could tell correctly the appropriate age of initiating complementary feeding increased from 49% - 65%
- Percent mothers who could tell correctly how to prepare ORS at home increased from 44% to 69%
- Percent mothers who could tell correctly when is hand washing necessary (after going to toilet, before preparing food, before eating, before feeding a child) increased from 68% to 80%
- Percent mothers who could tell the importance of boiling water for purification improved from 71% to 91%

PART TWO

STRATEGIC COMMUNICATION FRAMEWORK

Part Two applies the ideas from the communication strategies described in the last section, which all focus on certain aspects of MNCH. This framework combines behavior change principles from the social sciences with proven demand and supply marketing strategies to outline general guidelines for a comprehensive approach.

1) Background

Effective communication and service promotion interventions lead to demand for services or adoption of practices. The MNCH national program offers a variety of household and community service provision options: Lady Health Workers (LHWs) who bring health to “your door”; trained and skilled community-based midwives (CMWs); emergency and comprehensive obstetric and newborn care centers (EmONC) offering 24-hour care, seven days a week; ANC services; and child spacing products and services.

The opportunity exists for a National MNCH Communication Strategy that fosters demand for and utilization of MNCH services at the household- and community-level and adoption of household-level MNCH health risk management practices.

Demand is a result of creating value or benefit (to the target audience) for adopting a practice or accessing a service. The aim of a strategic communication and health service marketing efforts should be to create, communicate and deliver *value* (Kotler et al, 2008). The value that we ascribe to the services must be the value that the target audience perceives based on an understanding of the target audiences’ psychosocial needs.

While traditional communication and marketing approaches focus on the 4Ps: *Product, Place, Promotion and Price*, which are necessarily determined by the program; it is equally important to frame our interventions from the target audience’s perspective. For the target audience to be interested in our service “offerings”, they must have awareness of the offering and find them *acceptable, available at the right time and place, and affordable*; or the 4As (Sheth and Sisodia, 2008).

Affordability, availability, and acceptance of the perceived quality of the services are integral to demand creation. This communication strategy has the opportunity to serve as the bridge between supply and demand, or simply stated: the link between target audience wants and needs and service offerings. An overview of the situational analysis indicates a need for communication to strengthen the perceived value for MNCH practices and utilization of services at the household and community level. This value must be delivered, reinforced and maintained by the service provider at the facility and community level, in order to sustain practices and utilization of services.

Key factors affecting perceived value are addressed below:

- a) Insufficient awareness of major maternal and newborn complications among women, families and birth attendants persist.
 - Low risk perception of complications due to pregnancy, therefore, unfelt need for safe MNCH practices (perception that pregnancy is natural)
 - Lack of perceived benefits of safe MNCH practices from a target audience perspective
 - Lack of perceived demand for facility-based and community-based MNCH services, especially ANC services
 - Lack of communication capacity among community-based service providers (LHWs and unskilled birth attendants) to communicate danger signs, and complications
 - Lack of credibility of some LHWs because of their marital status or age
 - Value for tradition and relegation of healthy birth outcomes to “fate”

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- b) Despite an extensive health network, maternal and newborn mortality rates are high. Most maternal and newborn deaths occur at home, with no skilled health provider in attendance. According to available statistics, about 65 percent of women deliver their babies at home, while skilled birth attendants and trained TBAs conduct only 39 percent of deliveries.
- Lack of perceived value of accessing and utilizing skilled birth attendants (midwives)
 - Lack of perceived need for emergency obstetric services
 - Lack of “access” to basic and comprehensive EmONC
- c) Although substantial gains in the contraceptive prevalence rate (CPR) have occurred in recent years, a high total fertility rate (TFR) continues to expose women and children to increased risks of mortality and morbidity.
- Lack of perceived correlation between child spacing and healthy birth outcomes

2) Goals and Objectives

Overall Communication Goal

The overall goal is to develop and implement collaborative, cross-cutting communication, advocacy, mobilization, and service promotion initiatives that result in increased demand for and utilization of MNCH services and the adoption of recommended MNCH practices by key target audiences.

The proposed indicators below are program results indicators. Communication is an integral part of the program design and should by definition be the process to achieve results. Therefore, communication interventions and results need to be correlated and evaluated in regard to service uptake and adoption of health risk management practices.

Indicators of the communication strategy will demonstrate progress toward the desired affect on supply and demand of key services and behaviors.

Proposed Results (Indicators)

- Increase by x percent the number of births that are delivered by skilled birth attendants by 2015
- Increase by x percent the number of facility based deliveries by 2015
- Increase by x percent the percentage of women who receive any ANC visits with a skilled provider by 2015
- Increase by x percentage the number of women who receive 4 complete ANC visits with a skilled provider by 2015
- Increase by x percent the number of women who received two tetanus toxoid (TT) injections during their last pregnancy by 2015
- Increase by x percentage the number of women accessing EmONC facilities by 2015
- Increase by x percentage the number of women that delivered at home who received PNC within 2 days by 2015
- Increase by x percentage the number of women that delivered at home whose newborn received PNC within 2 days by 2015
- Increase by x percent the newborns who received the first bath >6 hours after birth by 2015
- Increase by x percentage the number of women with a live birth who put the newborn to the breast within 1 hour of birth by 2015
- Increase by x percentage the number of newborns <6 months who are exclusively breastfed by 2015
- Increase by x percent the total modern CPR by 2015
- Increase by x percent the women whose last and next to last births were at least 36 months apart by 2015
- Increase by x percent the total childhood immunization rate (using Pakistan epidemiology standards) by 2015

In order to complete the monitoring and evaluation plan of the communication strategies, baselines and targets must be established. (See Attachment G to be used as a worksheet for this process.)

Intervention Clusters

Using these priority focus areas and priority objectives; a strategic approach and framework for the overall national strategy evolved which is discussed in the Strategic Approach—Interventions Section. These objectives were clustered into two core interventions: Increase Demand for MNCH Services and Ensure Quality Supply and Access to MNCH services. Additional priority intervention areas were then clustered as process and support initiatives, e.g. community participation, advocacy, management.

Amalgamated Communication Objectives

- **Improve health behaviors of mothers, children and families—especially related to the most common and easily preventable causes of disease and death for the most vulnerable populations (mothers, newborns and children)**
 - Promote appropriate maternal health practices; empower women to take necessary steps during entire birth cycle to ensure a safe and healthy delivery
 - Promote appropriate neonatal health practices
 - Promote appropriate child health practices
 - Concentrate on preventative health practices
 - Enhance self-confidence and comfort level of individuals to take responsibility for healthy practices
 - Promote spousal communication
 - Encourage positive attitudes toward family planning and address myths and misconceptions
- **Promote maternal and neonatal practices**
 - Encourage birth spacing for the health of the mother and children
 - Promote proper nutrition (iron, micronutrients) and workload/rest levels during pregnancy;
 - Strengthen knowledge about direct relationship between mother's food intake and newborn's weight
 - Promote immediate and exclusive (to 6 months) breastfeeding; focus on benefits of colostrum
 - Promote clean delivery practices
 - Promote delayed bathing and warm wrapping (kangaroo position)
 - Promote importance of TT injections for mothers
 - Strengthen knowledge about danger signs of pregnancy, delivery and postpartum period
- **Promote child health practices**
 - Encourage complete immunization of children by the age of 2 years
 - Encourage use of oral rehydration salts (ORS) (whether home-made or packet) to manage diarrhea, especially in children
 - Encourage appropriate weaning/complementary foods
- **Improve health seeking behavior for MNCH, particularly from public sector primary health care and EmONC facilities**
 - Promote the fact that every pregnancy and childbirth requires special care at home and medical attention at the health facility
 - Encourage antenatal ANC visits (at least 4) for pregnant women; encourage immediate weighing of newborn at facility to detect low birth weight
 - Increase the number of facility-based deliveries
 - Promote post-natal care for mother and newborn (suggested protocol of 3)
 - Promote appropriate care-seeking for children with ARI
- **Promote the LHW as the community's link to the health facilities**
 - Improve social status (expert, trained, familiar) of the LHW
 - Encourage working ties between LHWs and TBAs/*daiyan* and CMWs
 - Promote menu of services concept
 - Reinforce LHWs direct liaison with BHUs and EmONC facilities and underscore referral role
 - Expand the health promotion work of the Male and Female Health Committees (HCs) as well as Women's Support Groups (WSG)

- **Improve overall health risk management at household and community level**
 - Promote household and community planning of health decisions,
 - Encourage forums for addressing community factors and conditions that lead to ill health
 - Promote safe delivery practices and neonatal care
 - Help people understand the benefit of going to a health facility
 - Promote birth preparedness; skilled birth attendance at home (with CMWs); and institutional delivery if possible—in order to protect the health and life of mother and newborn
 - Promote use of safe delivery kits
 - Increase household-level knowledge (husbands and family) of danger signs in mothers and neonates
 - Increase knowledge of *daiyan* of obstetric emergencies
 - To help reduce the first two delays, encourage community-organized revolving funds, blood donations and transportation

- **Support improvement of overall health service provision and quality of care at the health facility level**
 - Motivate service providers to provide client-centered care
 - Motivate service providers to have better communication with clients
 - Make the service providers at all levels more acceptable by increasing their social status
 - Promote filling vacant health provider positions and training of existing personnel in MNCH
 - Address lack of sensitivity to women's privacy by male colleagues

- **Promote cross-cutting issues**
 - Increase top of mind (ToM) awareness and create conviction of mothers, fathers, husbands, mothers-in-law and other key stakeholders about MNCH issues
 - Encourage male involvement and responsibility in maternal and child health
 - Increase overall priority for maternal and child health
 - Increasing risk perception (of not utilizing ANC, using a TBA, not immunizing, not exclusive breastfeeding, not starting breastfeeding early, not preparing for birth, not treating diarrhea, etc.)
 - Increase adolescent needs readiness for motherhood (FP, anemia)

3) Target Audience Analysis

The primary beneficiaries of improved MNCH health care, **women of reproductive age**, are restricted in their ability to seek timely and preventive health care for children and themselves because of socio-cultural practices affecting women's status. Moreover, those who influence women -- their husbands, and mothers-in-law -- do not feel a perceived need for accessing and utilization of MNCH services because pregnancy is perceived as a natural condition. Therefore the primary communication target audiences will necessarily be those who make health seeking decisions in the family: **mothers-in-law** and **husbands**.

Concurrently, supply-side communication efforts need to target **healthcare providers**, including facility-based as well as community-level providers, including LHWs, Lady Health Volunteers, and CMWs. The importance of this two-pronged approach is to ensure that the expectations that are being created for MNCH services through communication interventions are being met by the providers of the service.

A comprehensive MNCH communication strategy must address demand-side target groups as well as supply-side target groups.

Understanding Demand-side Audiences

The following are psychographic profiles of the key target audiences, which are used in marketing and communications to ascertain personality, values, attitudes, opinions, interests or lifestyles (Nielsen, 2008).

a) Mother-in-law: At the micro/household level, the mother-in-law is the decision maker for all MNCH-related issues as she is more experienced and is considered as the most senior in the family

(culturally). She is the gatekeeper for women to access MNCH services. Her key decision-making criteria are: personal childbearing experience (when the health services were not so advanced or easily available); tradition (her desire to project herself and her daughters-in-law as respectful of traditions, culture and age-old practices). Even among those who have information regarding the health services and advantages thereof, there is a hesitation/inertia to change the practice.

b) Husband: The husband is a strong influencer for most household-level decisions and he is the gatekeeper for the information in the household. He has the veto power if he wishes to take a decision about his wife and child. However, childbirth and pregnancy are considered to be woman's affairs and a husband who is perceived as too involved in pregnancy and child birth is perceived as "unmanly" in the community. This dissuades men to be involved in ANC and PNC.

c) Women of reproductive age: The pregnant woman is often aware that she can access the health center for better care, treatment and advice. However, if the mother-in-law disapproves, she does not insist. This is so because her relationship with her husband and her position with mother-in-law are the most important relationships. In her opinion, she can have more babies if this pregnancy is not healthy but she cannot fight or rebel against the mother-in-law or husband because she may then lose her home and husband.

d) Community leaders: Community and NGO leaders play a vital role in improving MNCH behaviors and practices in Pakistan. As respected bearers of advice, information and skills, they are role models for others. When strong local leaders are identified and empowered with the information, skills and resources they need to support MNCH, these leaders act as catalysts to improved health outcomes in their village, union council or district.

e) Ulema (i.e., religious leaders): The traditional religious institutions of Mosques, and *ulema*, have a strong influence in Pakistan. They play an important daily role in the lives of a majority of the population who refer to religious leaders for guidance on various issues, including factors concerning their health and well-being. In far-flung and hard to reach areas, the mosque is sometimes the only medium of communication with the communities. *Ulema* and Mosques have played a significant role in the success of polio campaigns in the past by supporting the immunization teams and can be leaders on MNCH issues as well.

Understanding Supply-side Audiences

a) Traditional Birth Attendant/*dai*: The TBA/*dai* is untrained and gets business because of networking and existing traditions. She accepts payment in kind and installments (a rational advantage over the health center). The *dai* services are available at home, which is preferred by several who find traveling to a health center inconvenient, expensive or immodest. Often the mother-in-law prefers the *dai* because she is comfortable with her, home birth is traditional, and it is less costly.

b) Lady Health Worker: The LHW is perhaps the biggest challenge to the *dai*. She is directly supported by the *Nazims* (i.e., town organizers), is trained and looks pleasant, young, and clean. However, she is often unmarried and not thought of as credible because of this. Over time she has developed relationships at the household level. She is the media channel for correct information and small medical supplies and medications. The translation from correct knowledge to correct behavior often does not happen because of her inability (lack of skill) to communicate her knowledge at an interpersonal level.

c) Health Service Providers (e.g., GPs, gynecologists, Lady Health Visitors, Women's Medical Officers, Medical Officers): All these health service providers have potential contact with the families, especially LHWs and Medical Officers in rural areas. The same roles are carried out by GPs, WMOs and gynecologists in urban areas. Communities are likely to go to these sources for verification of the information that reaches them through any media. However, they may be low on motivation and social skills, often having to cope with inadequate supplies and high patient load. This in turn discourages the demand side to utilize their skilled medical services.

4) Behavioral Objectives and Responses

The audience segments are targeted for Relevance (WHY we are targeting them); Behavioral Objective (What we want them to know, think, feel or do); and Behavioral “Hook” (WHY should they want to do it/WHAT will they get out of it). The behavioral hooks may be pre-tested to check their relevance to the varied socio cultural environment present in different regions of Pakistan. The following are the groups, their needs, and the offerings intended to satisfy those needs.

Demand Side

a) Husbands

Relevance: Birth preparedness and delivery often require financial and other resources that are mostly controlled by men. But pregnancy and child birth are typically seen as a woman’s domain, and men traditionally do not get involved in decisions involving pregnancy. Hence there is little/no financial planning for birth preparedness.

Behavioral Objective: To take responsibility/support their wives through their pregnancy (ANC, delivery, and PNC) and for the health and well-being of their newborns and children.

Behavioral Hook: They will have pride in being seen as responsible parents; society expects them to; role as a decision maker is reinforced; accessing ANC services can save money (on treatment and care of obstetric emergencies).

a) Mother-in-law

Relevance: Although she is often the primary decision maker and often the birth attendant, she is resistant to change.

Behavioral Objective: To promote the support and facilitation of ANC, delivery and PNC by skilled birth attendants. To foster correct newborn and child health care practices.

Behavioral Hook: Pride in having a healthy grandchild; future security in survival of healthy grandchild; status in the community; financial advantages; respect from daughter-in-law and son.

b) Women of reproductive age

Relevance: Women are directly impacted. There is a low perceived need for birth preparedness. Pregnancy is seen as a normal occurrence that does not require special preparations. When there is an obstetric emergency, she does not know how to respond. She has low perception of risk and low recognition of life-threatening conditions.

Behavioral Objective: To promote ANC visits, delivery, and PNC with a skilled birth attendant and to encourage safe new born practices and health care.

Behavioral Hook: Status among peers, reduced risk; mental physical and social (can relax, feel confident); reduce procedural risk; happy marital life; sense of security; reduce financial burden.

c) Community leaders

Relevance: They are role models who can inspire and mobilize people and resources.

Behavioral Objective: To encourage people to avail themselves of LHWs, CMWs and local health care resources and invite them to become actively engaged. To support upgrading facilities and services.

Behavioral Hook: Feel responsibility towards community; proud to help neighbors; further status, respect and recognition.

d) Ulema/Religious leaders

Relevance: They are tremendously influential and can reach many with empowering messages on Islam’s support for women’s rights, including to a safe pregnancy and delivery.

Behavioral Objective: To help promote health-seeking practices, dispel superstitions and incorporate accurate health information into religious educational activities.

Behavioral Hook: Responsibility as a spiritual guide; desire a role in reducing unnecessary suffering; known “ear” to the community and respected spokesperson.

Supply Side

a) Traditional Birth Attendants/*daiyan*

Relevance: Currently twice as many women deliver in their presence than at a facility because of proximity and low cost. But they are largely unskilled and may be propagating misconceptions.

Behavioral Objective: To improve ability to play an appropriate role during and after delivery by using clean delivery kits, understanding danger signs and offering accurate information/referrals.

Behavioral Hook: Chance to use unique and widespread access and connection to women and their families; potential to further training and education; garner more respect; increase reputation for playing a vital role.

b) Lady Health Workers

Relevance: They often have widespread first access to women and households, have training and potential to be great agent of change, including diffusing important health information and acting as a bridge to the formal healthcare system.

Behavioral Objective: Be service-oriented and proactive and provide accurate information/ rapid referrals.

Behavioral Hook: Role as compassionate caregiver to the community; want/need to win the respect of the community; involvement in programs and campaigns to increase my skills and get more training.

c) Service providers

Relevance: For those that are willing to pay, they are regarded medical experts and may come into contact with women or infants in an obstetric emergency.

Behavioral Objective: To increase the number of service providers communicating to families about ANC, birthing plans, skilled attendance and newborn care. Increase numbers trying to help make women feel more at ease during examinations.

Behavioral Hook: Better to promote and prevent; household/family preparation may prevent the need for an emergency visit; better service translates to a better reputation and more recognition.

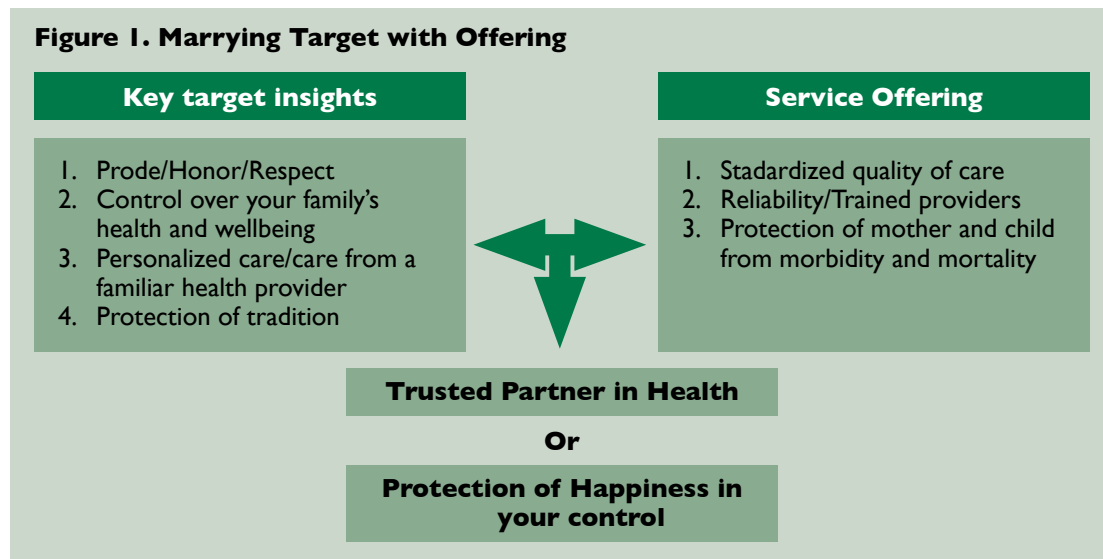
5) Strategic Responses

Based on an analysis of the key target audiences and their respective behaviors, the desired programmatic responses are to increase demand for and utilization of MNCH services at the household and community level and to promote the adoption of household-level MNCH health risk management practices (See next section on Strategic Approach -- Interventions).

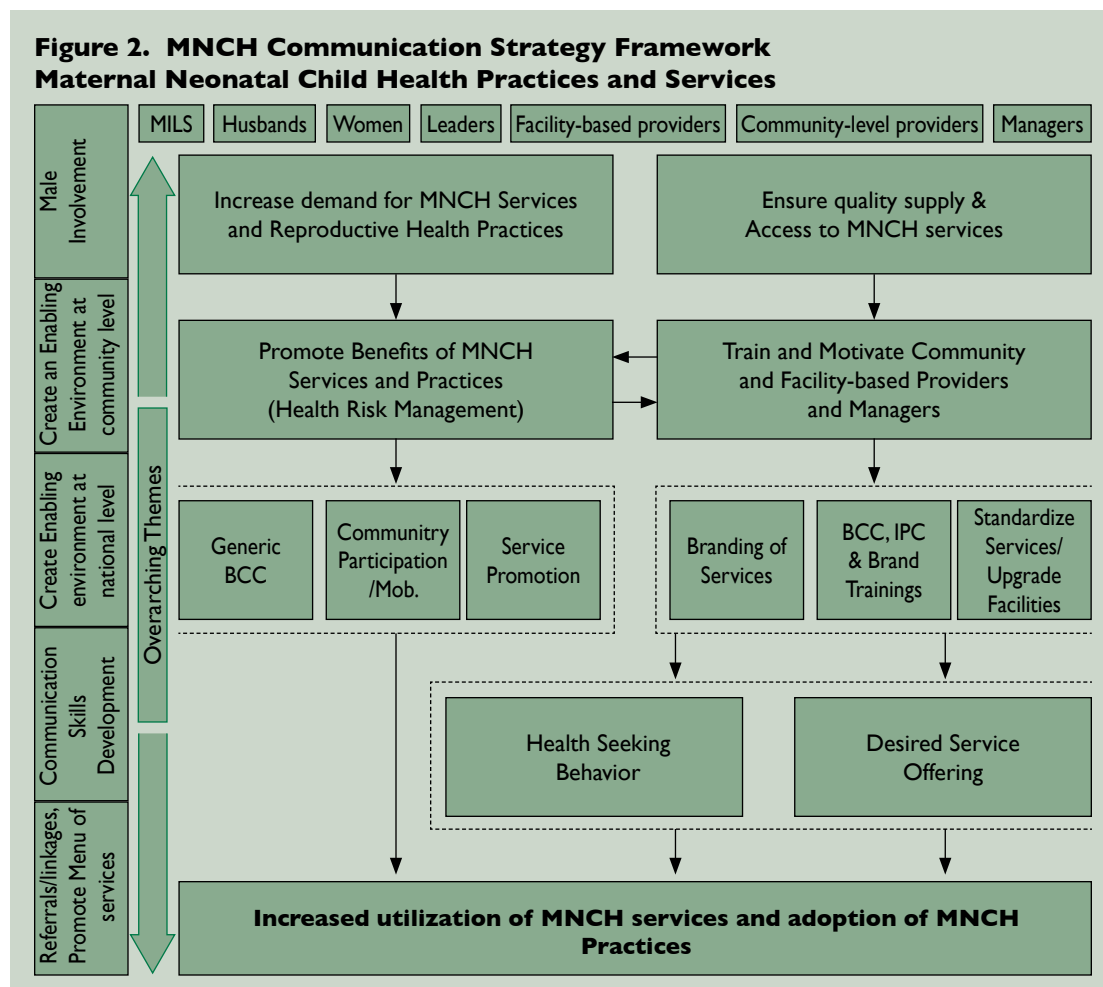
Demand is a result of creating value or benefit (to the target audience) for adopting a practice or accessing a service. The aim of strategic communication and health service marketing efforts is to create, communicate and deliver *value*. The value that we ascribe to the services must be the value that the target audience perceives based on an understanding of the target audiences’ psychosocial needs (Kotler et al., 2008, pp 7-8).

The strategic *behavioral* response is arrived at by distilling key behavioral insights or “hooks” defined above by each target group, and “marrying” those “hooks” with the program offering. Often, as in the graph below, behavioral insights can be cross-cutting among targets. Once identified, these “hooks”

are then “positioned” through the communication, or the advertising process. In Figure 1 below, the conceptual “marriage” of target wants with program offerings can be the basis for copywriters and creative professionals to develop brand names, logos, slogans, etc. This process involves partnering with skilled advertising and marketing professionals.



6) The Strategic Approach—Interventions



The key interventions necessary to increase utilization of MNCH services and the adoption of MNCH practices are represented in the above MNCH Communication Strategy Framework (Figure 2). The framework represents the synergistic components critical to a results-driven communication approach: **the demand-side communication component** and **the supply-side communication component**.

The demand-side cluster interventions focus on the importance of promoting healthy behaviors and desired health risk management practices at the household and community level. This is done by: a) selection of appropriate media and media outreach channels through BCC; b) engaging community participation; and c) by promoting the benefits of facility and community-based MNCH utilization.

The supply-side intervention cluster focuses on the need to increase access to and utilization of these services by increasing the perceived “value” of the services to the target audience. Service utilization, facility-based and community-based, is the natural entry point to address the majority of the above preventive health objectives. The manner in which to create “value” is identified as: a) the need to standardize service offerings/upgrade facilities and brand those facilities and services at both community and institutional levels (LHWs, CMWs, basic and comprehensive EmONC services) ; and b) to provide training to the providers as “brand ambassadors” of the services so that the expectations created by demand are being met, thus resulting in improved quality of care and improved value of services by the target audience. (Note: Standardization of clinical services and care is not discussed in this document; but is listed as a key intervention).

This results-based approach intends to foster health-seeking behavior on the demand side, and create a value for the services on the supply side (something the consumer desires) thereby leading to measurable demand for and utilization of MNCH services and adoption of MNCH practices. These core clusters of activities (as outlined above from forum small group discussion) serve as the core interventions of a National MNCH Communication Strategy.

Demand-side Cluster

a) BCC Communication to Promote Health Risk Management

This national strategy supports 15 messages essential to health risk management (see Attachment A). This includes 1) behaviors and practices related to antenatal care: the need for ANC check-ups, the number and at what intervals; TT injections; danger signs during pregnancy; 2) behaviors and practices related to birth preparedness: danger signs during pregnancy; definition of skilled birth attendants; danger signs during labor and actions to be taken 3) behaviors and practices related to post delivery including danger signs after delivery; 4) behaviors and practices related to neonatal care: when to bathe the neonate; early wrapping and keeping the baby warm; when to initiate breastfeeding; what is exclusive breastfeeding; and danger signs in the neonate; 5) behaviors and practices related to weaning; 6) behaviors and practices related to optimal period of birth spacing and 7) child immunization.

Gaps and Opportunities:

- **Communications Training.** Enough recent formative research findings exist that need to be analyzed by a cross-cutting group of communications experts. Since there are not enough trained Communications Managers or Officers at the federal or provincial level, plans to professionalize staff in various MNCH-related cells and departments with training should be pursued. Some seminars on Strategic Communication and Message Design can provide a fuller appreciation of behavior change methods beyond mass media.
- **Targeting men and husbands.** Since men may constitute a barrier to change due to traditional cultural beliefs and customs, there is a need for a national effort to target men and husbands in outreach. There are opportunities to capitalize on the male support groups that exist already, for example, Male Motivators and Male Health Committees. *Hujra/Chopaal* meetings among male elders can provide an entry point, too. Trained male facilitators should encourage spousal/household communication about shared responsibilities, sensitivity to women’s condition and need for them to reduce workload and rest. Birth preparedness and delivery often require financial and other resources that are mostly controlled by men. But pregnancy and child birth are typically seen as a woman’s domain and men traditionally do not get involved in decisions

involving pregnancy and birth. But husbands should know the hard facts about birth preparedness and plan accordingly: place of delivery, who will accompany mother, mode of transportation, financial requirements, etc. They should appreciate as well the importance of neonatal care and child immunization, etc.

- **Debunking myths.** The KAP studies with household interviews reveal the extent of the misconceptions. With BCC, there is a need to target the most dangerous and inaccurate health messages and negative practices, such as forbidden foods, mobility restriction, people and places to avoid, the evil eye, etc.
- **Existing materials.** A wealth of BCC material already exists that can be analyzed for appropriate adaptation, but funding needs to be set aside for production and dissemination.
- **Utilize existing structures.** If feasible, since Health Education Cells at the federal and provincial levels exist, the Health Education Officer and Media Officer at the Federal Program Implementation Unit (PIU) should be consulted and the Health Education Officers at the Provincial PIU be tapped as active partners.
- **Coordination.** Need to explore systems for better coordination among programs. A stronger link needs to be formed between Improve link between the National MNCH Program and LHW Program.

b) Community Mobilization and Participation

Current activities at the community level include community mobilization through LHWs who play a primary role, events by NGOs, household meetings by UNICEF, Male Motivators from MoPW, community mobilization by the Family Welfare Assistants; and community organizations that have been set up through community action processes (CAP) by partners.

Gaps and Opportunities:

- **Expand coverage of LHWs.** Since the program provides evidence about success in changing knowledge, attitudes and practices, it should be strengthened as a focal point for community level education, service delivery and referrals. Mobilizing through LHWs will guarantee at least 65 percent population coverage.
- **Clarify roles and responsibilities.** It is difficult for mothers, their families and the community at large to distinguish between certified midwives, TBAs/*daiyan* and LHWs. It has been recommended by almost every study that the three find a way to function as a team, each with suitable duties according to expertise, especially the responsibilities in an obstetric emergency. There has been a longstanding practice of training and building the skills of the LHWs. It would be strategic to focus some educational efforts on the *Daiyan*.
- **Expand reach of informal educational/social groups.** Since the LHWs can not provide enough coverage for their target area, more voluntary groups should be formed, e.g., mothers groups, Women's Support Groups, Health Committees, *Mohalla* meetings, etc. Women have reported being more comfortable speaking about pregnancy in an informal group. The LHW is charged with maintaining the male and female Health Committees. The use of Support Group Methodology to kick start efforts may address some issues of sustainability.
- **Community Mobilization Officers (CMO) positions.** The PAIMAN project has considerable experience that can be tapped in formulating Community Mobilization Teams (with one male and one female CMO) by district based in areas around RHCs selected for upgrades (see *PAIMAN Community Mobilization Tools and Approaches*).
- **Need for monitoring.** For community-level activities, each community will differ on ways to gauge how the process is going but it is a necessary component. The essential ingredients need to be worked out about who/what will be monitored, how often the core leadership team should convene, etc. At the very basic level, the following serve for discussion:
 - Are we doing what we said we would?
 - What difficulties have we faced?
 - How well are things going?
 - What have we learned?
 - How have we increased awareness?
 - What evidence do we have of behavior change?
 - Are we gaining local political support/visibility?

c) Service Promotion

Given the fact that most existing service centers are underutilized, it is essential to create a national, provincial, and district strategy that promotes services at all levels; creates awareness of the services and their benefits; and promotes their accessibility, availability and affordability.

Gaps and Opportunities

- **Targeted marketing.** Marketing is not target oriented enough and messages are not consistent. Current activities do not connect the promotional messages with the available services. The MOH, DOH and MoPW need to lead the process of coordinated marketing campaigns with input from development partners.
- **Need to build credibility.** Since there is a lack of trust of public health facilities and service, which could be based on isolated experience, out-of-date information or hearsay, there is a chance that not all their complaints are realistic/valid. It is important to sensitize the uninitiated women and her family to formal medical processes so they know exactly what constitutes intake, an examination, drug procurement, etc. There is an opportunity to spotlight basic and comprehensive EmONCs, in particular, so women and their families become people familiar with the providers that constitute a part of their Birth Preparedness and Complications Reduction Plan.

Supply-side Cluster

a) Branding of MNCH Services

On the provider side, quality of care for MNCH services encompasses a set of standards and protocols. From the consumer perspective, or demand side, quality of care is more intangible. It is a cluster of emotions; feelings of being cared for, respected, treated without judgment. These are easier to represent through a brand. A brand is what creates value for the service; it is the connection between the service and the target audience, it augments the target audience's perception of quality and links it to their needs and priorities.

Branding of service delivery points will ensure that health services are viewed by the target groups as essential part of their life and will help in enhancing the perceived value of the services and its delivery. Branding will also help in improving the social value of service providers and improve their morale and motivation at an intrinsic level. Branding can include the service providers both at the facility level and the community level who deliver the brand's "promise". This can include lapel pins, scarves, etc. but must be supporting through a brand orientation training (as described below).

Gaps and Opportunities:

- There is the opportunity to brand obstetric services and to further designate and differentiate by hours, e.g. comprehensive emergency obstetric care, basic emergency obstetric care, and basic health units.
- The standards for these facilities have already been institutionalized. There is an opportunity to refresh the brand image of the LHWs in order to upgrade her image and credibility.

b) Service Provider Orientation

The health center facility is the point of delivery of the "promise" made through the demand generation campaign and the promotion of the brand. As such, the facility should be reflective of the various attributes of the brand as perceived by the target groups. The target audiences come to the facility to access "services" but they go back with "experiences." On-site branding and signage should aim to enhance that experience. This form of signage also acts as a reminder to service providers about what is expected of them and how they should communicate with the "clients." In addition to "branding" facilities, service providers can be branded through uniforms, lapel pins, scarves, etc. The LHWs who are the links to the facilities, can be an extension of this brand, and will need to be included in this branding effort along with CMWs. Service managers and providers will need to be trained and oriented as to what the brand represents and their role in upholding the brand through their communication and interaction with the clients.

Communication training and brand orientation enables the program managers and providers to

ensure quality services. For instance, we are creating expectations, or demand, among the target audience through communication media about quality of MNCH services and at the same time providing communication support to the providers as well as point of service (client-provider) materials to reflect quality service to maintain quality “supply”.

Gaps and Opportunities:

- While a module is present for the LHWP, and partners are conducting communication training, there is no emphasis on communication in the curriculum for providers.
- There is the opportunity to institutionalize communication training in terms of content, human resource needs and cells.
- Consensus will need to be built around training methodology.

Cross-cutting Issues

a) Advocacy: A Critical Component

Since social norms and public policies influence behavior change, political leaders, policymakers, journalists and the general public are parts of the audience for most communication interventions. The process of advocacy entails raising the public profile of a problem, and building support for tackling the problem, legalizing or making a policy, allocating resources, etc. Once the benefits of health practices are confirmed by experience and people begin to talk publicly and advocate the practice to others, it cements conviction and sustains of the new behavior. Key advocacy audiences include the following:

Parliamentarians and District leaders (Nazims)

Under the Pakistan’s devolved system of local government, members to the National and Provincial Parliaments and those of the District Councils make the policy decisions including health. Emphasizing the importance of MNCH to these decision makers is crucial. Political commitment brings visibility to an issue, which usually results in allocation of funds for MNCH and will ensure continuity of the process. The program will inform and sensitize policymakers’ issues about the MNH situation and the steps they can take for addressing it.

Federal, provincial and district bureaucrats

The MoH’s role is policy development, standard setting, regulatory frameworks for drugs & services, development of national plans, monitoring, evaluation and research, resource mobilization and provision of services through federal health institutions. After devolution, the provincial DoH role is more in policy, intra-provincial coordination, medical and nursing education and tertiary care service delivery. Planners and policymakers exert a strong influence over decisions taken at all levels. Key decision makers will be targeted to help them understand MNCH situation and respond to the challenge by making more favorable policies. The messages to policy makers will foster around sensitizing them towards the issue and provide information on the harms of risky behaviors and their disability effects on economy and development at the community as well as country level.

Journalists

Print and broadcast may have a limited role in creating awareness about MNCH issues in rural Pakistan, but mass media is still a very important advocacy channel. The core of any media advocacy work must involve media managers, editors as well as the journalist who report on the issues to equip journalists with required knowledge and skills to cover issues such as women’s right to life and quality MNCH services.

Gaps and Opportunities:

- Since there are frequent changes in leadership and coordination of the advocacy effort is challenging, there is a need for advocacy planning and agreement on a policy agenda that represents “one voice”.
- Advocacy needs to be coordinated and lead by the National MNCH Program. Currently there exist a number of advisory panels: a Technical Advisory Group for the National MNCH Program, a Technical Committee on Innovations for the LHW Program and a Technical Advisory Group (TAG) for PAIMAN. There is also an Advocacy Advisory Network for Newborns, a White Ribbon

Alliance, a national and provincial Oversight Committee; Donors' Coordinating Committee, and a National Coordination Committee for the FALAH project. There is also a National Communication Committee, a Health Policy Forum, and a National MNCH Steering Committee.

b) Management and Organizational Structures

Management and organizational structures will have to be strengthened at the three levels of government. In addition various options/innovations for strengthening organizational and management systems will be tested. In addition, emphasis will be given to strengthening of support systems such as the referral system, logistics system, and availability of essential drugs, etc. Capacity is needed in utilizing the Management Information System (MIS) as a vehicle to track personnel, quality assurance measures, etc. At the district level, the services provided through various MNCH related vertical programs (e.g., nutrition, malaria control in pregnancy, EPI, LHW program, population welfare, NACP, etc.) will be operationally

Project Management will be critical to the achievement of national MNCH goals and objectives. A Coordination Group for Communication Strategy and additional human resource expertise in the areas of communication, marketing, and market research are needed at the national level. Further, support in the procurement and logistics management of vendors and contractors that will be needed to establish and maintain the partnerships with ad agencies and research firms that will assist in implementing the national MNCH communication strategy (see *Attachment D for the Agency Capacity Assessment*; and *Attachment E for the Sample RFP for Ad Agencies*).

For the National MNCH Communication Strategy to be successful, it is critical that strategic alliances with ministerial agencies, partners and stakeholders be formed to complement and/or leverage capabilities and resources. The alliances should achieve common benefit for the parties involved. For instance, trainers of the CMWs will have to partner with the LHW Program in order for the two to approach TBAs and households as a team.

For each intervention cluster; lead partners should be identified and their key role identified. Gaps in capacities will enable the MNCH National Program to identify resource needs (see *Attachment F*).

Media Planning and Channel Selection

Demand is a function of decision (decision to seek a product or service). If there is no decision, there is no demand. It is therefore necessary that to generate demand we must understand the decision-making process of the customer and identify opportunities to influence the choices at various points of the process. Commercial advertisers, as well as health care organizations world-wide, utilize this tool to understand the decision “buying” process of the customer and to select media based on this understanding (Kotler et al., 2008, pp. 155-163).



Starting with problem recognition, the consumer then passes through information search, evaluation of alternatives, purchase decision, and post-purchase behavior. The buying process starts long before the actual purchase and has consequences for repeat purchase or return health care visits. The model provides a frame of reference, as it captures the full range of considerations that arise when a consumer faces a high involvement new purchase. These stages, simply stated are **trigger, consider, search, choose, use** and **experience**. A combination of mass media, inter-personal communication and community-based approaches will be used at various stages of the customer decision-making process (see *Attachments G1 and G2 for the sample decision-making templates*).

An overview of the types of communication will be produced and disseminated at different stages of the decision making process is given below. Based on this or any stage of change model, appropriate communication stimulus should be selected.

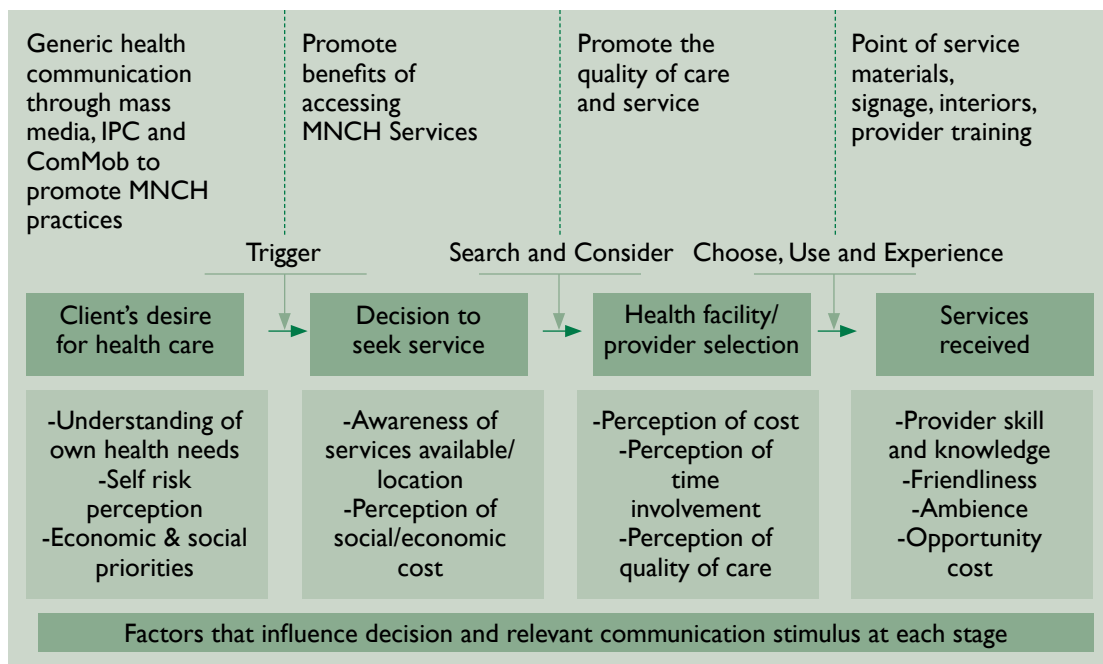


Figure 3. Decision-making Factors

As is evident from the above figure, the demand-side interventions and supply-side interventions converge at each stage of the target audience's decision-making process.

7) Implementation Controls and Plan

a) Implementation Principles

Stakeholder Collaboration

The National MNCH Strategy will be implemented by various stakeholders and implementing agencies. Stakeholders working on common issues and common goals are often constrained by their funding requirements and area of operation. The operational success of this strategy will heavily depend on collaboration between partners and agreement on implementation protocols and parameters.

The Core Group would serve as the collaborative committee to oversee and maximize the potential of synergic partnerships. Stakeholder collaboration must work at several levels including standardized messaging approaches, standardized creative development approaches, standardized implementation planning and execution and standardized monitoring and evaluation protocols. This is necessary to avoid duplication of work and to ensure that specific segments of populations are not missed out.

Reduction of Duplication

There are various BCC materials that have already been developed on MNCH issues. The process will aim to collect and adapt successful BCC materials and interventions and avoid duplication. The existing materials used by agencies should be examined for scaling up through coordinated efforts and involvement of the stakeholders. Consultative workshops and sessions should be organized at the national, provincial and district levels to develop standardized messages and standard creative themes. The creative guidelines should be developed centrally whereas the actual execution of creative ideas should be done separately in each area and each ethnic group.

Phased and Tailored Execution

All materials and interventions developed through the National MNCH Strategy should be piloted before they are scaled up. Also, some areas are more exposed to MNCH related BCC interventions as compared to others. In such cases, it is critical to understand the level of awareness and intent for behavioral change for each segment of population and tailor interventions to match the status of the

target groups. The type of interventions, types of messages and the type of M&E will depend on the existing level of exposure of the target groups.

b) Implementation Process

The process for the implementation of the MNCH Strategy has to follow a systematic and synergetic approach that is both inclusive and participatory. The following key steps need to be followed:

Team Building and Strategic Alliance Workshop

The first step in the process of implementation of this strategy should be a Team Building and Strategic Alliance workshop, including all key stakeholders involved in the MNCH program. This would involve donors, MoH representatives, implementing agencies and other partners and stakeholders. This will be the most critical rendezvous as all implementing agencies need to sign off on the strategy and agree on roles and responsibilities by cluster (see Strategic Alliance Worksheet in Annex F). Considerations at this stage should be made of existing IEC/BCC materials and whether they are suitable to be scaled up/adapted for reproduction in other regions. A review of the materials should be done based on the core intervention clusters to consider whether the materials serve to promote demand of MNCH practices or promote quality supply of services. The role division should be based on relative strength, area of operation and mandate of each party involved.

Also at this stage, specific human resource and personnel needs should be determined (e.g. the type and kind of communication personnel needed, as well as the external support from professional ad agencies, production house, etc.) Communication expertise should include not only a theoretic understanding of behavior change, but the ability to prepare a creative brief that will guide the ad agency, the ability to review and provide direction on creative productions, the ability to understand and review media plans, the ability to gauge cost-effectiveness of advertising “spends”, etc. This assessment of human resource needs should also include an assessment of procurement capabilities (e.g. personnel available to prepare and negotiate ad agency contracts).

Formation of a Core Group and Development of Operational Plan

The document in hand has been developed to serve several stakeholders in the area of MNCH in Pakistan which include public sector, local NGOs, partners, donor funded projects, private sector etc. Along with the primary user of this strategy i.e. MNCHP, LHWP, Nutrition Wing and EPI and MoPW, the other organizations may have to develop their own operation plans in the light of the guidance provided in this document. The individual draft plans will be a function of the each organization's demand driven by its scope, context, coverage, life, budget etc. As a next step it is being proposed that at the very onset a core group may be vested with the responsibility of developing the operational plan for MNCH Program in the light of the guidance being provided in the strategy. This operational plan shall respond to the program priorities and help the program in taking off with respect to its communication objectives. This operational plan could serve as a reference plan for other organizations to develop their own plans etc and the core group may thereof oversee the development of these operational plans such as for LHW Programme, EPI and Nutrition programs.

Hire Professional Vendors/Suppliers

Using the template in Annex D, the core management team should conduct an assessment of ad agencies/marketing firms in order to short list companies. Using the sample Request for Proposal (RFP) in Annex E, the next step would be to draft an RFP for specific services. The ad agencies will prepare a technical and cost proposal for review by the Core Group. The team may decide to hire different agencies for different interventions. Following the process outlined in the RFP, they should hire the ad agencies. Following the same process, at this stage, the Core Group should also hire a research firm who would pre-test the creative materials or conduct ad-hoc research as needed.

Commission Work from the Ad Agencies

The next step is to commission work from the ad agencies by developing Scopes of Work and Contracts. The starting point is typically the technical and cost proposal submitted by the ad agency and then negotiated by the Core Group. Based on the MNCH Strategy, the ad agencies should provide a detailed creative as well as strategic approach that includes a well-thought out media plan (media planning is discussed below).

Develop Creative Strategy and Media Plan

The creative strategy should be developed by the ad agency in response to the SOW. The creative strategy typically consists of creative ideas, and approaches based on a strategic tool such as the “consumer buying process” (Annexes G1 and G2) or any other decision making process used by the agency.

Develop Ad Agency Implementation and Logistics Plan

Using the sample Implementation and Logistics Plans in Annex H and I, the ad agency in coordination with the core team should detail the time table for implementation, media plans, roles and responsibilities for dissemination and the required quantities of various materials (logistics plan). This plan should clearly lay down the resource requirements for implementation in terms of personnel requirements, transportation logistics, etc. The plans should be appended as part of the ad agency contract with deliverables. The ad agency should work with the indicators provided to them to develop appropriate materials, as well as their own monitoring mechanisms. Ideally the agency would tie its creative, strategic and media planning to the defined indicators.

Research Plan

Based on the implementation plan, research should be planned in parallel to the creative process, so that the research teams are ready to field test the materials when materials are ready. A systematic pre-test research should be conducted using the resources of established research firms that can provide scientific and unbiased research results. All creatives should be tested for the following basic enquiry areas and modified if need be:

- Spontaneous reactions;
- Likes and dislikes;
- Comprehension and retention;
- Creative magnifier;
- Relevance/user imagery;
- Creative material's ability to create intention for behavior change.

In addition to pre-testing services, a research firm may need to be retained in the creative design process (e.g. to conduct psychographic research, or insight mining in new regions, or among ethnic groups.) Research firms may also be utilized to monitor communication; such as exit surveys at the health delivery site. Monitoring communication is discussed in the M&E section below.

Tailoring and Production of Materials

At this stage the pre-tested materials (new and adapted) should be made ready for production. A production plan must be developed that lays out the timetable for production.

Detailed Implementation Guidelines and Requisite Training

Before the start of implementation it is critical to lay down the implementation guidelines for the actual user and disseminators of the materials. This should include guidelines on material usage and distribution. Training needs should be identified and service providers who will use the communication materials (especially the IPC materials) should be trained on the use of these materials.

Monitoring and Evaluation

The entire communication development effort should be monitored and evaluated. Key indicators relating to inputs, process, outputs and impact should be identified and laid out. Data points and data collection methodology should be specified to ensure accurate and regular collection of data for required indicators. (Please refer to Monitoring and Evaluation section for more details.)

8) Communication and Dissemination Strategy

a) Understanding Media

Before starting any form of media or dissemination planning, it is important to understand how media works. Each media can be looked at from three perspectives:

- **Medium as Medium:** This refers to the physical attribute of the medium. For example, television is audio-visual and is therefore suited for visual demonstration of concepts.
- **Medium as Message:** Each medium carries a hidden message. It is imperative for PR managers and communication experts to identify those hidden messages. For example, a program on a news channel like the BBC automatically has a level of integrity in the consumer's mind. The government news channels though could be perceived as politically motivated.
- **Medium as Form:** Medium as form refers to the format in which messages are disseminated through a medium. For example, on television it is possible to do TV spots, TV dramas, talk shows, documentaries etc.

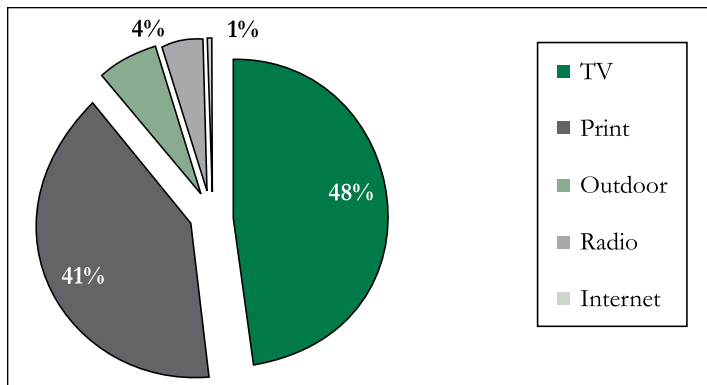
It is recommended that communication managers and implementers conduct media research before developing the final media plan. This research should ideally be conducted for all major target audiences. Suggested areas of enquiry include:

- Review media survey data;
- Media consumption habits of key target groups (by medium, channel and time slots);
- Authenticity and credibility of various media (refer to 'medium as message' above);
- Credibility of media format (refer to 'medium as form' above);
- Cost implication of various media choices.

b) Understanding Overall Media Context in Pakistan

Pakistan has a relatively strong mass media network with a plethora of TV channels, radio stations and newspapers. The outdoor medium is also quite effective and a relatively large portion of the advertising spend is spent on the outdoor medium. Internet is a relatively new but fast-growing medium. The chart below shows the relative importance of the various media measured through the relative media expenditure.

Figure 4. Relative Importance of Media Measured through Expenditure



Total advertising expenditures have increased from 20.57 billion in 2006-07 to 24.36 billion in 2007-08 (an increase of 18 percent). In 2007-08, television advertising has increased by 28 percent, print media expenditure increased 13 percent, radio 76 percent, whereas outdoor spend has decreased by 25 percent. If this trend continues there may be a resurgence of radio as an important medium.

Television. There are 10 million TV sets in Pakistan (approx.) which are split 50:50 in urban and rural areas. There are about 40 million TV viewers (18+) of which only 28 percent live in rural areas. Viewership in electrified homes is 49 percent and in non-electrified homes is 19 percent. It is critical to note here that TV is considered to be the most credible mass media by both urban and rural media, followed by newspapers.

Radio. Radio ownership and listenership in Pakistan is surprisingly low. Radio contributes to mere 4 percent of the total advertising spend in the country. The *PDHS 2007* report reveals that population access to radio in rural areas is merely 36 percent (lower than that of TV). Furthermore, in terms of exposure to family planning messages of rural women, radio accounts for just 11 percent and television for 33 percent.

Newspapers. Overall readership corresponds with the literacy rates and variation in the literacy rates across urban and rural populations (urban: 60 percent; rural 35 percent; all Pakistan 45 percent). Readership on any given day is 30 percent of the 18+ populations.

Key factors for channel/media election include:

- *Media environment:* What kinds of choices are available for message dissemination?
- *Media reach:* What is the expected reach of a particular media? Reach is always measured in

relation to frequency of exposure (how many times a message needs to be delivered through the media for it to have impact)?

- *Media type:* Is the form of the media compatible with the kind of messages that needs to be delivered? Is the media credible?
- *Media cost:* What is the cost per reach of the media in relation to the expected impact of the media, for example, inter-personal communication has a much higher cost per reach but also has a higher impact.
- *Monitoring options:* How easy or difficult it is to monitor the efficacy of the chosen media?

c) Role and Context of Different Communication Channels

Following section describes the different communication channels which can be used to impart messages to different audience for achieving communication objectives. The selection of the communication channel/s will be determined by the different factors such as reach, availability, cost implications, project scope etc.

Television (Local, National)

The reach of television varies in Pakistan. Over the last several years numerous private sector channels have emerged, but PTV is still the most widely viewed channel, with the highest reach across the nation.

Pros: Television helps in broader reach of communication messages and is ideal for creation of a supportive environment for messages. Has high impact as high frequency of exposure can be achieved through TV. And it allows for visual demonstration of concepts that may be otherwise hard to explain.

Cons: Ownership and reach of television is limited in rural areas. Some subject matters like pregnancy and child birth are considered a taboo in the visual medium.

The role of television in MNCH campaigns would help to:

- Create instant awareness through paid spots;
- Create a supportive environment through talk shows and other programming where more detailed issues can be covered;
- Facilitate long-term behavior change through use of communication tools, such as enter-educate drama serials and other programming.

Television can be used at the national or regional level depending on the target audience and the intended reach. It is recommended that wherever possible a combination of public and private sector stations should be used to avoid sense of bias.

Radio (National, Regional)

Radio ownership in Pakistan is surprisingly low. However despite low ownership and low level of listenership, radio can play a vital role in reaching some of the hard-to-reach target groups. The following type of radio stations could be used:

- National and regional stations reach a wide range of mass audience.
- Community radio stations can be used for targeted and spontaneous messaging. New community radio stations could be developed along with radio listening clubs to create focused behavior change environment.
- Religious stations and religious programs are extremely popular, especially in peri-urban and rural areas. They have high credibility and messages delivered through these stations.

Pros: Ideal for creation of a supportive environment for messages to be accepted. Has high impact as high frequency of exposure can be achieved through Radio. Radio is the highest reaching medium in Pakistan.

Cons: Visual demonstration is not possible through radio.

The role of radio for the MNCH campaigns would be used to help:

- Create instant awareness through paid spots;
- Create a supportive environment through talk shows and other programming where more

- detailed issues can be covered;
- Facilitate long-term behavior change through use of communication tools such as enter-educate drama serials, radio listening clubs, community radio etc.

Radio can be used at national, regional and community levels. It is recommended that wherever possible a combination of public and private sector stations should be used to avoid sense of bias.

Newspapers and Print Magazines

Newspaper is the ideal medium for reaching men, educated decision makers, opinion leaders and policy makers. There is a large diversity in the quality and quantity of newspapers across Pakistan. However, perceptions about different newspapers vary.

Pros: Detailed information can be provided. For example, a launch of new health facilities or new programs or policies can be announced through newspapers. Magazines allow for very targeted communication especially for reaching groups, such as women (through women's magazines) and policy makers. Usually the printed word carries high level of credibility.

Cons: Given the low rate of literacy in the semi-urban and rural areas, the print medium can have limited impact in mass campaigns.

Although print medium is not as popular as TV or radio due to limited literacy rates, limited circulation and limited readership, Newspapers, magazines and journals would be an important medium for reaching the educated target groups and carried high credibility factor. This medium could be used in the following ways:

- Press conferences;
- Invitation of media persons to different workshops/events;
- Featured articles;
- Press ads to promote health products and services.

Events and Sponsorship

Sponsorship is a form of paid communication where the sponsors capitalize on the popularity of the event or program that they sponsor, such as Samsung sponsoring the Olympic Games. This form of communication allows the sponsor's ability to ride on the popularity of existing opportunities and saves the cost for creating new opportunities.

Events at the national and local levels would play a critical role in the MNCH strategy. Events at national and local level provide significant exposure and create media hype that may be difficult to generate through paid media. Events allow opportunity for direct one-on-one interaction with the target groups. They are localized in nature with strong cultural nuances and therefore target groups respond to events more positively. The events (created or sponsored) would create the rallying point for MNCH and give it a much needed hype factor. Events provide a forum for exchange of ideas, formal and informal interaction as well as widespread publicity.

Inter-personal Communication

Inter-personal communication (IPC) refers to on-to-one or one-to-many communication and can be conducted at the top level with policy makers as well as the grassroots level with program beneficiaries and service providers. It is the most relevant tool for reaching the semi-urban and rural communities. IPC should be used extensively as an essential element of communication and sensitization activities.

Pros: IPC uses the power of direct interaction, persuasion and education through a two-way dialogue. Pakistan has a large force of frontline workers, such as LHWs, LHVs and other service providers who are a critical vehicle for IPC.

Cons: Whereas, IPC stands as a persuasive method for promoting behavior change it does have some limitations such as quality control, cost effectiveness, reach, availability etc.

A different level of IPC could be conducted with policy makers and other influencers at various forums organized by the implementers of the MNCH Strategy. Materials could include customized e-mails, electronic newsletters, press lists, Q&A/FAQs sheets, etc.

The IPC skills of the health care providers need to be enhanced and they need to be provided with efficient, easy-to-use and effective communication tools, such as flipcharts, cue cards, talking books, etc. There should be mechanisms for capacity enhancement as per growing needs of the service providers.

Social Mobilization

Socio-cultural factors play an important role in health-seeking decisions. In this context, social mobilization involves creating a supportive environment at the community level through involvement of key stakeholders, such as opinion leaders, community leaders, religious leaders and other local-level leadership. Social mobilization goes hand in hand with a media campaign or any other method of communication by generating discussion, reinforcing the message, reducing anonymity, giving currency to the changed behavior, pooling of the resources and collective actions. It helps change the social norms and attaching value to the propagated behaviors. It leads to the generation of a social capital which exists in the form of networking which acts as a catalyst for a behavior change. Social mobilization is critical for affecting behavioral shifts among the semi-urban and rural communities. Social mobilization should be used extensively as an essential element of communication activities. The partnerships with community based organizations and groups are useful in social mobilization. The opportunities need to be identified by implementers for specific programs, which could include:

- Activation and capacity development mobilizers;
- Local level events;
- Enlistment of support from local level leaders, religious leaders, etc.;
- Creation of special groups such as the Mother-in-law groups or husband/father groups;
- Workshop and conferences involving community members and stakeholders.

Localized Media

There are different local media that are used across Pakistan, including local radio stations, use microphones/loudspeakers, religious congregations, branded taxis, sign posts, billboards, posters, leaflets etc. All these media have their relevance in the context in which they are used and form an integral part of the overall media mix.

They are most relevant for reaching communities and general public. Messages can be tailored according to the area, and cultural differences/specific nuances can be addressed through the use of localized media. Specific local media activities need to be identified for each province, tehsil and village.

Brand Ambassadors

The concept of brand ambassadors is becoming quite popular among international organization intending to promote social causes. The mileage gained through such brand ambassadors is unparalleled. The concept of brand ambassadors is not new to Pakistan and, in the past, TV stars, cricket stars and film stars have been used as brand ambassadors.

Internet

Internet is fast becoming one of the most important media in the world. Its effectiveness in Pakistan varies by area and by target group. It is an ideal medium for reaching urban, educated populations that have access to the Web, including policy makers, young people, media professionals, private sector, etc. It is an excellent medium for creating interactivity and enlisting youth in development activities.

9) Prioritization and Scheduling of Interventions Activities

The communication and/or service promotion interventions proposed in the strategy cannot and should not be implemented simultaneously. Each of these intervention clusters requires a significant level of preparation and is designed to achieve very specific results. It is therefore necessary to prioritize and schedule them through a strategic approach.

Overall the clusters can be divided into three key stages.

Stage 1: Community Preparedness

This first stage involves generalized BCC to help create the need for improved health behaviors and tap the latent need for accessing the services of health providers and health centers. This stage should be accompanied by advocacy at all levels.

Stage 2: Health Service Readiness

At this stage, it is critical to ensure that the health facilities are suitably geared to provide quality services. The community preparedness stage helps tap the demand; this stage, on the other hand, will ensure that health facilities are ready to supply services.

This stage includes the following supply-related activities:

- Branding of MNCH Services to establish customer expectations;
- Service Provider Orientation to help in delivering the promise of quality.

This stage can often begin within 6-8 months of the launch of the first stage. From that point on, both stages can run in parallel.

Stage 3: Activation

This stage will motivate individuals to adopt appropriate behaviors and access requisite services and will prompt communities to take action to provide the necessary support and milieu. This stage will help complete the behavior change cycle and ensure sustainability.

This stage includes the following demand-driving activities:

- Community Mobilization and Participation to activate community-level organizations, such as Village Health Organizations and religious and civic groups;
- Service Promotion to help in selling targeted service providers at the various levels of the health management system.

This is a direct action phase and requires that the above two stages have been satisfactorily implemented. This stage should be launched about 6-8 months after the launch of the second stage. After that, all three stages can run in parallel with varying degrees of intensity depending on the results of monitoring and evaluation.

I0) Monitoring and Evaluation Plan

M&E is an integral and distinct part of program planning and implementation. M&E is a critical tool for forward-looking strategic positioning and learning and often has a two pronged purpose:

- **As an oversight mechanism.** M&E is expected to *influence decision-making*, including decisions to improve, reorient or discontinue the evaluated intervention or policy; decisions about wider programmatic strategies and evolving issues and realities. For this purpose, M&E provides the latest information on trends and deviations and on new issues emerging so that informed decision could be taken. Participation and dialogue are required for wider learning, while independent external evaluation is often considered a prerequisite for accountability.
- **As an evaluation mechanism.** M&E works as an audit and evaluation to determine the extent and significance of the intervention. The evaluation helps in exploring the return of investment of the program (i.e., investment being that of social effort, funding, time and other opportunity costs). In other words, a *program evaluation* not only contributes to improvements in implementation methods, but also to significant changes in program design.

For the purpose of the MNCH program M&E strategy that addresses both the accountability as well as the situational monitoring should be developed and implemented.

a) Monitoring, Evaluation and Research Plan (MERP)

A strong and focused M&E Plan is essential to manage and time all the major research and monitoring

activities that will take place for specific program. For a multi-year program, the plans are developed and executed at three levels:

- **Multi-year Plans:** During the planning of a multi-year project, landmark M&E projects are underlined with their tentative timelines. For example: the Midline evaluation is usually conducted when the program is approximately into its half tenure.
- **Annual Plans:** For a multi-year program, the annual monitoring and evaluation activities involve monitoring of process, indicators for achievements and indications of new emerging issues or trends. These would include annual compiling, audit and analysis of health center records; collection and compilation of statistical facts relevant to the program that would work as a monitoring of the program progress.
- **Ad-hoc Research Projects:** As part of the process, or to explore specific areas of interest to the programmatic interventions several ad hoc researches are undertaken. For example: Before the launch of a new service, the facility often researches the variables of the service and how it is expected to be received. The audience is often researched at the time of communication development.

b) Annual Program M&E Plan

The process of development of the M&E plan begins with the program plans, priorities and targets. These will provide the overall direction as well as the end goal against which the performance will be either audited or to access its achievement the M&E would assist in information gathering for informed decisions.

Based on the overall goals and strategies of the program or any element/component of it, indicators are developed. Indicators refer to those parameters/variables that indicate on an element of the program. For example: an MNCH program strategy is to reduce use of TBAs. The indicator for this strategy against which the program can be evaluated in its achievement of this objective will be: Percentage drop in women using TBAs for deliveries.

With Annual Working Plans developed and a list of key indicators identified, all major research, M&E activities must be assembled into the annual planning format. This will include those originally identified in the multi-year M&E projects as well as any new ones identified through the Annual plans and processes. As with the multi-year planning, opportunities for integrating M&E activities across sectors/programs are examined.

(See Table 3 for an example of indicators and information needs.)

c) Communication Monitoring and Evaluation Needs

The M&E needs for the program's communication element are threefold:

Communication Development: The research focuses on exploring the subject to be communicated and the audience who will be reached. Several types are used during communication development:

- **Insight mining and lifestyle studies:** These qualitative studies are intensive projects that probe into the overall social-cultural-political-economic-psychological fabric of a certain segment of society in which communication will operate.
- **KAP (Knowledge, Attitude and Practice):** This is an exploratory research that probes into the knowledge, attitude and current practice on specific issues.
- **U&A (Usage and Attitude) Studies:** Usage & attitude studies investigate all aspects of the relationship between consumers and a specific service or market. They provide the basic foundations for marketing activity by providing a full understanding of the market into which a product or service will be, or is already being launched.

Communication/Campaign Monitoring: These include short-term or long-term monitoring and auditing of campaigns and materials to evaluate the success in achieving objectives:

- **Route/Concept/Execution Pre-test:** Concept pre-testing is a systematic method of obtaining and measuring the reactions of a representative group on the key insights and the creative route/line of thought that is being planned to be used for the program campaign
- **Analysis of Creative Magnifier:** The Creative Magnifier is that element of the creative message execution that is the key creative hook as well as has the key message. The strength of the Creative Magnifier directly relates to the impact the creative is likely to have.
- **Exit interviews:** Interviewing to explore the perception of a service through semi-structured questionnaire as audience leave after the use/experience of a service is called an Exit Interview.
- **Post tests/Dipsticks:** Dipsticks/post tests are all quick-and-dirty ways to explore and indicate the direction of response towards any creative/product or service.
- **Qualitative Evaluations:** Evaluative and exploratory research to explore the 'Why' and 'How' behind the 'What' and 'How Many'. These are used to explain or explore specific issues and problems during the program implementation.

d) Impact Evaluations: These evaluations focus on the overall impact of the communication on the achievement of overall program goals/annual plans:

- **Mid-line and End-line Campaign Evaluations:** These are holistic qualitative and quantitative evaluations exploring all the relevant indicators to assess the success, if any of the program. The indicators, target audience and the type of locations for the midline and the end line often remain similar to the baseline so that the results of the three research assignments remain comparable.
- **Media Evaluations:** These include the analysis of the reach and frequency of mass media to evaluate efficiency of use. The media researches explore how each media is being consumed and each message being comprehended. This research provides both oversight for future planning as well as the evaluation of the ongoing planning.

Table 2. Example of M&E Indicators and Information Needs						
Overall Goal	Strategy	Impact Indicator	Output Indicator	Process Indicator	Input Indicator/ Information Need	Information Gathering Methodology
To increase the demand of Facility Based Births	To create a high value of unborn life and address attitudinal hurdles and mis-conceptions towards facility based deliveries. To create risk awareness and perception for non-facility based deliveries	X% of women opting for a facility based delivery	X% of women who have correct knowledge regarding ANC, delivery and PNC. X% of families who plan for facility based delivery	X number of messages developed on risk perception of non facility based deliveries and benefits to mother and infant of facility based delivery. X number of messages delivered/ communicated through TV, radio, BTL etc. X number of target audience reached and messages recalled	Number of health facility deliveries. Qualitative Current KAP to understand key motivators as well as attitudinal and behavioral hurdles etc regarding child birth and delivery Inputs on media habits and use.	<i>Quantitative info:</i> Baseline data and analysis/audit of facility records <i>Qualitative info:</i> Insight Mining Lifestyle studies and thematic evaluations; Observations <i>Media:</i> Qualitative Media Consumption research; Desk Analysis of various message themes already used and the corresponding audience response Monitoring of TV spots, radio spots, BTL Implementation; Quantitative figures on reach and recall
To make available for every one access to Trained Birth Attendant	Supply side: to make available trained and professional birth attendants in the health facilities	X% of women delivering with a trained birth attendant	No. of Trained Birth Attendants	No. of medical trainings. No. of workshops. No. of refresher courses. X% of birth attendants trained in medical as well as the social elements of their jobs.	<i>Baseline mapping and information on:</i> No of birth attendants and health facilities. <i>Monitoring of trainings and workshops for birth attendants.</i>	<i>Baseline mapping:</i> Quantitative and qualitative evaluations on the training requirements; Analysis/ audit of health facility records <i>Monitoring needs:</i> Exit interviews Observations Case studies

II) Next Steps

Various plans have been laid out and templates developed. A number of actions should be considered and decisions taken as part of the next steps forward.

Responsibility for coordination. Although technical expertise on MNCH resides in a number of Government programs and bilateral and multilateral projects, the ultimate responsibility for the coordination and execution of the MNCH Communication Strategy has to clearly exist with one Government entity to ensure accountability and facilitate fiduciary decision-making. As envisioned in the National Maternal and Child Health Policy and Strategic Framework (2005-2015), this would be the National MNCH Program.

The ten Core Group members for the MNCH Communication Strategy exist, but they may need a clear mission statement and operational strategy. They will be ushering the strategy through implementation and will be recommending the best use of already budgeted communication components and provide guidance on what should be programmed into various budgets from hereon in, according to the consensus built throughout the Strategy Framework process. This group can be viewed as the management team that can maximize partnerships and assure standardized approaches. They would also have to decide how to best coordinate with donors interested in funding communication and a marketing approach to creating demand and reinforcing quality supply. All stakeholders should be aware of the structure and function of the Core Group and modes for collaboration.

Strategic input from an international management consultant. It was agreed that professional communication skills should be developed within government programs. However prior to that stock-taking exercise, it is important to engage in a broader team-building analysis of existing and potential partner alliances. A management consultant could help frame the structures and functions of every partner involved in MNCH work in Pakistan to best identify areas of collaboration to avoid duplication. There should be a plan for getting the most out of the turnover of short-term projects so that more capacity resides with the Government agencies. This consultant could also look at the inventory of existing advisory bodies and recommend methods for best capturing, broadening and sharing their findings and recommendations.

Mentoring from a senior-level retired marketing executive or chief operating office for a health organization or company. In order to proceed with a skills upgrading and training plan, it would be ideal to get input from a very high-level private sector marketer from a healthcare-related corporation like Johnson & Johnson or Procter & Gamble. This individual could mentor the MNCH Program and Core Group members in outlining the structure of a more comprehensive Communications Team, as opposed to a few individuals. For a demand-supply approach, expertise in market research, advertising, sales promotion and merchandising, production and distribution as well as interpersonal communication are all important for team members. Part of the strategy would be to identify the competencies within the local marketing and advertising world as part of a capacity-building process to build up a permanent team.

Twinning with an international marketing/management consulting firm and ad agencies: Twinning is a practice used in other countries to develop local capacities through the knowledge and experience of international companies and individuals. The approach proposed in the MNCH strategy reflects approaches used by commercial marketers and manufacturers. Ideally the hiring of an internationally recognized marketing or management consulting firm is recommended to help shepherd through the implementation of the MNCH strategy. It is recommended that this be a firm based in the region, possibly Dubai or Malaysia, with Islamic sensitivities, which may have operations in Pakistan through distributorships, ad agencies or other such alliances. This international firm would “twin” with the local ad agencies, as well as the core team, and MNCH program, with the goal being to leave behind state-of-the-art approaches to demand creation, health-seeking behavior and provision of quality services and supply.

(Note: Annexes appear in a separate document.)

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National MNCH Program
Ministry of Health
Government of Pakistan

National Maternal, Newborn and Child Health (MNCH) Communication Strategy Framework for Pakistan: Annexes

Annex A. List of Core Group Members for MNCH BCC Strategy

1. Dr Rehan Hafeez (MNCH Programme)
2. Dr Salim Wali (MNCH Programme)
3. Mr. Mazhar Nisar (HEA, MoH)
4. Ms. Sheeba Afghani (UNICEF)
5. Dr Zaeem ul Haq (LHWP)
6. Ms. Tanvir Kiyani (MoPW)
7. Ms. Elena Immambocus (DFID)
8. Communication Specialist (FALAH)
9. Muhammad Ihatsham Akram (Communication Specialist, SC/US)
10. Mr Fayyaz Ahmad Khan (Johns Hopkins University)

Annex B. Unified Health Messages

(Finalized at one-day Consultative Workshop organized by NP for FP & PHC, July 25, 2008)

No.	Issue	Suggested Content
1	Antenatal check-up: when to start, how many and at what intervals?	Four ANC check-ups starting from one in 1 st , one in 2 nd and two in 3 rd trimester
2	Tetanus Toxoid (TT) injections: how many and when?	Regardless of previous status, two TT injections are useful
3	Danger signs during pregnancy	<i>(in Urdu)</i>
4	Who is a skilled birth attendant?	Introduce the cadre that are designated as Skilled Birth Attendants (SBAs)
5	Danger signs during labor (3)	<i>(in Urdu)</i>
6	Post-partum examination: when?	At least one check-up within 6 hours after delivery
7	Danger signs after delivery	<i>(in Urdu)</i>
8	Bathing neonate after birth: when?	Delayed bathing is advised to avoid hypothermia and keep the protection of vernix intact
9	Early wrapping and keeping baby warm	Baby's body, including head, should be wrapped properly to prevent hypothermia
10	Breastfeeding: when to initiate?	Prevents neonatal deaths as it improves resistance to many diseases
11	Danger signs in the neonate (5)	<i>(in Urdu)</i>
12	Exclusive breastfeeding: what is it?	Mother should know that even water deprives the child from advantages of breastfeeding
13	Weaning: when to initiate?	Breastfeeding should continue until the age of six months, an appropriate time for weaning
14	Optimal period of birth spacing	Optimal birth spacing should be known to couples
15	Child immunization	Families should know and complete the immunization Course for their children

Note: Original document had "Suggested Urdu Phrases" for the content but could not be reproduced here.

Annex C. List of Participants for MNCH BCC Strategy Development Workshop

(Dubai, October 27-28, 2008)

1. Dr. Amanullah Khan, Deputy Director Health, Save the Children US, PKCO)
2. Ms. Nabeela Ali (Chief of Party PAIMAN)
3. Mr. Saleem Wali Khan (Technical Adviser, NMNCHP)
4. Mr. Akhtar Ali Hakro (National Coordinator, Lady Health Workers Programme)
5. Mr. Zahid Iarik, Nutrition Wing, MoH
6. Mr. Imtiaz Malang, National Project Manager, Nutrition Wing, MoH
7. Mr. Mobashar Hanif Malik, National Programme Officer, UNFPA
8. Mr. Fayyaz Ahmed Khan, Team Leader, JHUCCP/PAIMAN
9. Mr. Salar Khan, Provincial Project Director, NMNCHP
10. Ms. Sheeba Afghani, Communication Adviser, UNICEF
11. Dr. Zia Dawar, Deputy Programme Manager, NMNCHP
12. Mr. Muhammad Yousaf Bizimjo, Provincial Project Director, NMNCHP
13. Mr. Sahib Jan Badar , Provincial Project Director, NMNCHP
14. Dr. Shoaib Khan, Director Programmes, JSI/PAIMAN
15. Dr. Zareef Uddin Khan, National Programme Manager Child Health, JSI/PAIMAN
16. Mr. Muhammad Ihatsham Akram, BCC Specialist, Save the Children, US, PKCO
17. Mr. Toby Chaudhuri, HDI
18. Ms. Susan Howard, HDI
19. Mr. Mishaal Anjum, AC Nielsen
20. Ms. Faiza Jamil, AC Nielsen

Faciliators: Susan Howard, MPH
Siddhartha Swarup, MBA

Howard Delafield International

Attachment D.

Advertising Agency Capacity Assessment - (for short-listing agencies)

1. Experience of the Agency

- (a) Total number of years of experience of the agency
- (b) Width of Experience:
 - List of accounts handled by the agency
 - Variety of accounts handled
 - Commercial/Brands vs. Social accounts handled
- (c) Focused Experience:
 - Specific Experience in handling MNCH or similar issues
 - (In addition to the above inquiry areas the agency is required to fill out the 'Project Experience Format' provided as Annex I)
 - Experience in handling projects for international NGOs, Ministerial Agencies, donor agencies

2. Human Resources

- (a) No. of employees / staff / personnel in the agency – by department and designation
- (b) Agency Organogram
- (c) Employee turnover rate
- (d) Capacity to get additional human resource (need based)
- (e) Experience of key personnel
(Request CVs of Key Personnel)

3. Physical Resources

- (a) List of technical equipment in use (including computers, facsimile machines, photocopiers, phones, editing machines, studio facilities, cameras etc.)
- (b) Internet connectivity
- (c) Office area, studio, warehouse facilities
- (d) Other assets owned by the agency which may be relevant to their performance
(The agency is required to fill out the 'Physical Resources Format' provided as Annex III)

'Physical Resources Format' to be completed.

4. International Networking

- (a) Joint ventures, affiliations, associations, alignment with any foreign communications company (if any)
- (b) Plans of joint ventures, affiliations, associations, alignment with any foreign communications company
- (c) Nature of affiliations/joint ventures (Technical affiliation, equity sharing, project based collaboration, etc.)
- (d) Any prior experience of the agency in working with foreign communication companies on a specific account or otherwise. Describe the nature of cooperation.

5. Strategy Planning Capacity

- (a) Communication strategy development process/methodology followed by the agency
- (b) Provide an example of a project where such methodology was used illustrating various stages involved
- (c) Provide an example of a project where a relevant consumer insight was used. How was the insight arrived at? How was it used?
- (d) Experience in dealing with objective bound communication campaigns
- (e) Experience, if any, in handling communication campaigns based on client's communication planning methodology (e.g. P-Process of JHU or ABC of Unilever)

6. Creative Development Capacity

- (a) Provide samples of 5 best creatives (TVCs, Press ads, BTL items etc.) and 3 worst creative items of the agency
- (b) Delineate the creative philosophy/guiding principles of the agency
- (c) Sample creative/s developed by key creative people prior to joining the agency which illustrates their creative aptitude may be provided separately

7. Capability to Translate Strategy to Creative Concepts and Ideas

- (a) Explain the creative briefing process followed by the agency
- (b) Provide samples, if any, of the creative briefing format used by the agency

8. Production Resources

- (a) Experience of the agency in handling large scale production jobs
- (b) Explain how production of different creative items is handled by the agency. Who does what?
- (c) Does the agency have its own production facilities or is the work outsourced? Name the key third parties the agency deals with for production purposes.
- (d) Explain why/how the agency is best equipped to provide best production deals for the client.

9. BTL Implementation Resources

- (a) Experience of the agency in handling below-the-line activities
- (b) What resources does the agency possess to implement large scale BTL activities like events, sampling, postering, point-of-sale material distribution etc.)

10. Public Relations (PR) Capability

- (a) Experience of the agency in handling PR activities for clients
- (b) What resources, contacts does the agency have to handle PR
- (c) Relations of the agency with different newspapers, TV channels etc
- (d) Provide sample/s, if any, of PR coverage organized by the agency for any clients

11. Media Planning and Buying Capacity

- (a) How is the media planning and buying function handled in the agency? What is the process? Who does what?
- (b) Is the agency equipped to procure media discounts for clients?
- (c) Describe media research, if any, used for doing media planning
- (d) Describe the media planning tools, if any, used by the agency
- (e) Describe any media innovations initiated/executed by the agency

12. Turnaround Time

- (a) Provide a time plan for designing, developing, producing and implementing the proposed campaign.
- (b) Does the agency have resources to speed up the process, if required?

13. Financial Strengths, Systems and Transparency

- (a) Provide the figures for total billing (account-wise) of the agency in the last 3 years
- (b) Describe the accounting system followed by the agency
- (c) Provide financial statement of last 3 years
- (d) Mention legal liabilities of the agency, if applicable

14. Billing Rates and Charges

- (a) Describe the system followed by the agency for billing the clients. Make distinction between time costs and commissions where applicable.
- (b) Provide the rate sheet used for billing clients on creative development and production jobs

15. Networking with Experts

- (a) Provide details of technical experts that the agency has access to (Camerapersons, Technicians, Playwrights etc)

16. Partnerships / Collaboration

- (a) Collaboration, associations, partnerships, alignment with any local companies/firms that provide lateral or vertical integration for services provided by the agency (such companies/firms may include media buying companies, production houses, research companies etc.)
- (b) Explain nature of relationship with such partners

17. Research Capacity

- (a) Does the agency have any research capacity to conduct small/large scale researches required to understand the consumer or do insight mining during the strategy or creative development process
- (b) Describe the research facilities/capacity available with the agency (if applicable)
- (c) Provide an example of research conducted by this outfit on any prior projects of the agency
- (d) Has the agency worked in collaboration with an external research firm?
- (e) Describe the research and how the findings were applied by the agency

18. Relations with Government

- (a) Provide details, if any, of any political affiliations of the agency with any existing or otherwise political party/organization

Annex II: CV Format

Name:

Position Held:

- Name:
- Date of Birth:
- Nationality:

Education:

Year	Institution	Degree

Professional Trainings Received:

Skills:

Language and Degree of Proficiency:

Language	Read	Write	Speak

Project Experience:

Experience on health or MNCH related Campaigns:

Experience in Other Social Communication Campaigns:

Employment Record:

Year	Name of Employer	Employment Status	Position Held	Country of Employment

Any other Relevant Information:

Key Expertise:

Annex III: Physical Resources Format

Equipments	Type/Software	Number	Other info
Computers (IBM Compatible)			
Computers (Mac)			
Printers			
Scanners			
Scanner			
Photocopier			
Facsimile			
Phones including mobile			
Car			
Generator/Inverter			
Other assets/ equipments			

Attachment E. Request for Proposals: Advertising Agency/ Marketing Firm

January 2009 (SAMPLE)

The *MNCH Stakeholder Forum* (illustrative client) invites locally registered and experienced marketing/advertising firms to submit proposal to help design, produce and implement a national health promotion campaign (including healthier behaviors at household level; demand for appropriate health services; and branding and service promotion campaigns). The work done by the firm will result in measurable improvements in selected health behaviors (focused on mothers, newborns and children); *and* increased demand for, and utilization of, essential health services.

I. INTRODUCTION

A. Background

The situation of maternal, newborn and child health (MNCH) in Pakistan is one of the poorest in South Asia. Despite some improvements in the 1990s, Pakistan still lags behind many neighboring countries in terms of health and population outcomes.

In the past decade, the Government of Pakistan has been committed to addressing this critical area of health in a number of key areas: first, by supporting and expanding the very important Lady Health Worker (LHW) Program, which consists of a network of 100,000 community-based primary care workers; second, in creating a National Maternal, Newborn and Child Health cell within the Pakistan Ministry of Health (MOH) to help build a national strategy and program; and, third, by training a new cadre of community-based midwives (CBMs) to address the need of skilled birth attendance. Similarly, a number of international and bilateral agencies, as well as nongovernmental organizations (NGOs) have begun investing substantial funds in support of these initiatives that seek to expand access and quality of MNCH in order to achieve progress toward the Millennium Development Goals.

The Government decided that comprehensive advertising, marketing, promotional and outreach strategies would lead to a demand for and utilization of more services at the household and community level, and adoption of healthier practices and outcomes. To this end, a three-day participatory workshop was organized by Save the Children USA in Dubai from October 27-29, 2008 entitled "Finding a Common Voice: A Consensus Building Forum towards a National Communication Strategy" in order to share and explore tools and guidelines for use in a national unified approach to MNCH communication for demand creation and behavior change. The forum was conducted by the marketing and communications firm Howard Delafield International (HDI). HDI's innovative approach to behavior change communication employs commercial advertising approaches with social, cultural and public health sensibilities while focusing on direct-response outcomes.

In this regard an advertising partner is sought to achieve results that enable the national program to achieve its program objectives outlined below. To assist in the achievement of these objectives, the *MNCH Stakeholder Forum* seeks the services of a full-service professional ad agency.

B. Goals and Measurable Outcomes

Overall Communication Goal: To develop and implement collaborative, cross cutting communication, advocacy, mobilization, and service promotion initiatives that result in increased demand for and utilization of MNCH services and the adoption of recommended MNCH practices by key target audiences .

The proposed indicators below are program results indicators. Communication is an integral part of the program design and should by definition be the process to achieve results. Therefore, communication interventions and results need to be correlated and evaluated in regard to service uptake and adoption of health risk management practices.

Indicators of the communication strategy will demonstrate progress toward the desired effect on supply and demand of key services and behaviors.

Proposed Results (Outcomes):

- Increase the number of births that are delivered by skilled birth attendants by 2015
- Increase the number of facility based deliveries by 2015
- Increase the percentage of women who receive any ante natal care visits with a skilled provider by 2015
- Increase by the number of women who receive 4 complete ANC visits with a skilled provider by 2015
- Increase by the number of women who received two tetanus toxoid injections during their last pregnancy by 2015
- Increase the number of women accessing EmONC facilities by 2015
- Increase the number of women that delivered at home who received postnatal care within 2 days by 2015
- Increase the number of women that delivered at home whose newborn received postnatal care within 2 days by 2015
- Increase the newborns who received the first bath >6 hours after birth by 2015
- Increase the number of women with a live birth who put the newborn to the breast within 1 hour of birth by 2015
- Increase the number of newborns <6 months who are exclusively breastfed by 2015
- Increase the total modern contraceptive prevalence rate by 2015
- Increase the women whose last and next to last births were at least 36 months apart by 2015
- Increase the total childhood immunization rate (using Pakistan EPI standards) by 2015

II. Role of the contractor

Interested eligible firms must be locally available and have proven technical and financial capacities to:

- Develop an overall brand and communication strategy to promote healthy behaviors and desired health risk management practices at the household and community level; and to promote care-seeking and utilization of facility and community based MNCH services in order to achieve the above indicators
- Develop innovative and media clutter-breaking creative executions
- Implement key communication interventions at different levels and with various target audiences including mass media interventions, BTL (below the line) activities and provider brand orientation.
- In this regard the contractor should have the following capabilities:
- Strategic Planning capability for designing multi-media campaigns and social mobilization implementation
- Creative and production capacity to develop print and electronic media communication materials
- Production capabilities for all relevant communication materials (directly or through partners/associates)

B. Target Groups for the Campaign

The campaign will cut across all social sectors including under-served rural clients and peri-urban areas, newly married-married couples, expectant mothers *and* fathers, marginalized populations, as well as middle class populations. In all cases, priority should be given to increasing access to services by women of reproductive age and children under the age of five. A specific segmentation strategy would be devised to cater to different target audiences most relevant to different service categories and different locations and types of clinics.

The secondary target audience for the campaign would include decision makers and influencers at HH level and community level.

The tertiary targets would be service providers.

C. Strategic Plan

A comprehensive communication plan and creative strategy to address all the above outcomes and related issues should be proposed by the advertising agency/ marketing firm.

The following will be the key campaign components on the demand side and supply side:

Demand side Components – generic behavior change communication, demand creation for specific services, and community participation and mobilization

Supply Side Components – Branding of health centers, internal and external signage at the centers, service provider orientation on branding and communication

Branding will be the overarching component that will link demand and supply side components.

D. Communication Channels

A combination of mass media, inter-personal communication and community based approaches should be proposed. The contractor should make recommendations on the most appropriate channels for reaching the various target audiences for the campaign and should include use of innovative approaches, new and non-traditional media where appropriate. The contractor will be expected to understand the market conditions and health seeking behaviors of the target populations. Approaches should be such that they can be implemented quickly and effectively.

E. Contractual Relationships

The *Stakeholder Forum* will issue one award. Bidders can form consortia as long as one organization acts as the prime subcontractor; and there is a clearly articulated technical justification that describes the advantages of additional partners. In addition, the prime bidder must justify their capacity to manage a partnership of this type. This award will be in the form of a subcontract for an estimated 18 months.

F. Requirements

The companies and organizations that submit proposals must adhere to the following requirements:

- 1) Must be legally registered under the laws of Pakistan.
- 2) Must have a local presence in Pakistan at the time of signing the subcontract.
- 3) Must be wholly private (no government or government body ownership).

Bidders may present their proposals as a member of a partnership with other companies or organizations. The prime company or organization will be responsible for making all partnership arrangements- division of labor, invoicing, etc- with the other company(s) and/or organizations. A legally registered partnership is not necessary for these purposes; however the different organizations shall be committed to work together in the fulfillment of the subcontract terms.

III. Terms of the Bid

Companies and organizations interested in being considered must submit a proposal to The *MNCH Stakeholder Forum*. This section details the process by which these proposals must be written and submitted.

This document is only a Request for Proposals, and it in no way obligates the *Stakeholder Forum* to either award any subcontract or pay any of the costs incurred by the applicant in the proposal preparation.

Bids must remain valid for at least 90 calendar days after the bid deadline.

Please comply with the instructions below.

A. Contents of the Proposal

The proposal and other requested documents are intended to confirm the status of the applicant, the management and financial capacity to responsibly manage the budgets allocated, and the technical capabilities to undertake the proposed activities. Proposals should consist of the following three components: 1) Institution information letter; 2) Technical proposal; and 3) Financial proposal. Each of these three components is described below.

1. Institutional Information letter (1 page, suggested)

Bidders should include the following information:

- 1) Name of the company or organization
- 2) Type of company or organization
- 3) Address
- 4) Telephone
- 5) Fax
- 6) E-mail
- 7) Full names of legal representative (as appropriate)
- 8) A statement of responsibility and certification that the Bidder has sufficient financial, technical, and managerial resources to complete the activity described in the Scope of Work, or the ability to obtain them. This statement should not exceed one page.

2. Technical Proposal (Limit of 20 pages excluding attachments)

Bidders must submit a technical proposal that demonstrates the marketing firm or ad agency's ability to undertake and deliver strategic, high quality, multi-media communication campaigns in both rural and peri-urban areas of Pakistan. The technical proposal should include the following:

2.1 Technical Approach (10-15 pages, suggested).

All bidders must specify their technical approach for promoting MNCH practices and creating demand for the services. The technical approach should include the following:

- (1) Description of subcontractor's approach to implementing the Scope of Work, including agency's proposed strategy and approach to address the project's primary goal and each activity or category of activities (e.g., suggested media channels/format; main messages).
- (2) Initial Strategic and Creative Ideas - Subcontractors are asked to provide *initial* strategic and creative ideas for the branding of the Health Centers with a rationale for how it is designed to appeal to the primary target audience and why. A clearly articulated branding approach with samples of logo, signage and other materials to promote the brand must be submitted with the bid.
- (3) Technical approach to conducting formative insight mining research and conducting pre-test research studies for all creative materials proposed. (Formative insight mining research is a qualitative research undertaken to understand target audience's motives, desires, fears, hurdles and any other factors that influence their responsiveness to communication & branding).
- (4) Sample Media Plan and Schedule - Draft media plan describing what media will be used, how often, when and why within a possible 18-month contract period. **Note:** Sample media plans are being requested to evaluate the subcontractor's ability to think creatively and strategically given the aforementioned target group. However, consumer research is being conducted to guide the selected agency in developing the final media plan.
- (5) Proposed production timetable based upon an 18 month time frame for design, development launch and implementation.
- (6) Proposed Staff - Staff members who will be assigned to this account; percentage of their time, which will be devoted to this account, description of staff experience, how the account team will manage this account

2.2 Corporate Capabilities and Past Performance (3-5 pages, suggested)

The bidder must provide details of their corporate capabilities in the area of brand management, communication strategy development, creative development, media planning and buying, print and electronic production, BTL and community mobilization implementation. Internal and external resources and experts should be mentioned clearly.

The bidders should also provide details of prior experience in designing campaigns, which communicate and promote health behaviors and related products. Previous and current experience in management and promotion of healthcare brands and non-healthcare brands should also be highlighted.

(Please refer to the evaluation criteria in Section 4 for guidelines.)

3. Financial Proposal (No page limit)

The financial proposal must include the following:

- (1) Time Cost of all proposed staff members and external experts (Time cost should include strategic planning costs)
- (2) Design cost for various items proposed
- (3) Production Costs of all items proposed
- (4) Proposed media and implementation costs

B. Key Elements and Important Dates to Remember

Key elements of the competition include:

- **Request for Proposals (RFP) release date: (TBD)**
- **Submission of Questions:** Companies and organizations that are interested in applying for the contract may submit questions to (TBD) by 17:00 local time on (TBD).
- **Proposal submission date:** All proposals must be received by 5:00 p.m. on (TBD) at (address). No late offers will be considered.
- **Proposal Evaluation:** The *MNCH Stakeholder Forum* Evaluation Committee will evaluate written submissions and will score the proposals based on the evaluation criteria set forth in Section III of this document.
- **Oral Presentations:** The *MNCH Stakeholder Forum* Evaluation Committee may require short-listed applicants for an oral presentation of proposed ideas for brand and services promotion. Applicants should be prepared to give a presentation to the Evaluation Committee **within 5 days of receiving notification.**
- **Contract Award:** The Evaluation Committee will select the best value applicant based upon technical scores, bidder presentations, and financial proposals.

C. Procedures for Submission of Bids

The “technical proposal” should contain information about your company or organization’s capacity and proposal. The “Financial Proposal” should contain the estimated costs that your company or organization expects to incur in order to undertake your plan. In order to create a fair bidding process for all companies and organizations, please adhere to the following procedures for submitting technical and financial proposals.

- **Technical and financial proposals will be scored separately.** Therefore, technical proposals should not make reference to costs. This will enable the Evaluation Committee to evaluate the technical proposal strictly on the basis of technical merit.
- **The technical and financial proposals must be submitted in separate sealed envelopes.** Each envelope should be properly marked with the name of the bidder’s company or organization
- **An electronic copy of both the technical and financial proposals must be submitted on either diskette or CD-ROM in .PDF format**
- The technical proposals should be submitted on standard A-4 sized paper
- Each Bidder must submit 3 hard copies clearly labeled of the full technical and financial proposals, in addition to an electronic submission in PDF format .
- All documents must be submitted in person or by mail by 5:00 p.m (local time) on (TBD) to the following address: (TBD)
- The Committee reserves the right to request additional information if it is deemed necessary.
- Information provided by applicants will remain confidential for use only by the Committee.

IV Evaluation Criteria

Any award will only be made to a responsive applicant whose offer follows the Request for Proposal (RFP) instructions, meets the technical specifications, and is judged to be most advantageous to the MNCH national program in terms of technical quality, personnel qualifications, experience, and price. In judging the bids, the Evaluation Committee will evaluate the proposals as follows:

A. Technical Proposal –

Capacity & Experience – Total 40

1. Experience of the Agency	Total marks:	15
2. Human Resources	Total marks:	10
3. Production & Implementation Resources	Total Marks:	5
4. Research Capability	Total Marks:	10

Technical Approach– Total 60 Marks

1. Strategic Approach	Total Marks:	10
2. Creative Approach	Total Marks:	20
3. Execution & Implementation + Time Plan	Total Marks:	15
4. Research Methodology	Total Marks:	15

B. Financial Proposal

1. Billing Rates and Charges	Total Marks: 0 (will be negotiated)
	Total Marks: 100

Attachment F. Strategic Alliances Work Sheet based on Demand and Supply-Side Clusters

CLUSTER	LEAD PARTNER		COLLABORATING PARTNERS	
	Name	Key Roles/Responsibilities	Name(s)	Key Roles/Responsibilities
<i>Demand Side</i>				
BCC to Promote MNCH Risk Management				
Community Mobilization/ Participation				
Service Promotion				
<i>Supply Side</i>				
Branding of Services				
Brand Orientation to Service Providers				
Standardize Services/ Upgrade Facilities				

Annex G I. Decision Making Process			
Decision Making Process	What are they doing? What are they thinking and feeling? Where are they?	What do they need? Where are they?	What is the role of communication? What do we need to say? Where do we do it?
Trigger			
Consider			
Search			
Choose			
Action			
Experience			
Loyalty			

Target Audience:

Service/Practice that we are promoting:

Annex G.2. Sample Decision Making Plan

Stage	What they are doing?	What are they thinking and feeling?	What do they need? Role for communication (next column(group exercise)
Trigger (mother)	Young woman finds out she is pregnant (about 8 weeks)	<p>“I wonder if it is a boy or a girl” “I hope nothing goes wrong” “My husband is going to be so happy” “Who should I tell?”</p>	<p>“Relax” “You are going to be ok” “You are going to be a mother!” “Start thinking about care” “Prepare yourself”</p>
Consider	Pregnant woman is talking to her sister-in-law / mother-in-law / about what to expect <i>Mother in law</i>	<p>“What is going to happen to me?” “What did my sister-in-law experience?” “Should I be worried?” “Are they telling me the truth, or just trying to reassure me?” “I am the best person to advise my daughter-in-law” “I will call the dai to check on you” “My mother will manage my wife’s pregnancy”</p>	<p>Create perceived need for antenatal care “Take care of your body during pregnancy” “Taking care of yourself means taking care of child/family” “You need to know what is happening to you and your body” “The baby should have a good birth weight” “You need supplements/nutrition – fortification of blood” “You can get pills from a health center” “Your unborn grand child and daughter-in-law needs the best possible care” “Listen to your grandchild’s heartbeat” “Get more involved in your caring for your wife and unborn child”</p>
Search	Pregnant woman is listening to her mother-in-law’s (and others’) advice about what to do	<p>“What care do I need? Where, should I go?” “Does the dai offer helpful antenatal care?” “What do health facilities offer?” “Will it be expensive?” “Will a female service provider be available?” “Who are the nearest care providers?”</p>	<p>Consider what a dai can or can’t provide during pregnancy Provide alternate options for ANC “There is good care available” “Your health center offers antenatal care” “LHVs can help”</p>
Choose	Pregnant woman is planning to visit health center <i>Mother-in-law</i> <i>Husband</i>	<p>“Where is the nearest ANC center?” “How will I get to the health center?” “Who will accompany me?” “How can I convince my mother-in-law/husband to get me to the health center?” Who will do my house chores while I am away? “Will my husband/mother-in-law be happy with the treatment I receive?” “Are these government facilities really worth visiting?” “Will they give better advice than I can give?” “How do I make sure my wife gets proper care and keep my mother happy?” “Will it be expensive?” “Should I go with her or ask my mother to go with her?”</p>	<p>“Your nearest facility is X distance away – closer than you think” “There are benefits of facility based care” “Support efforts to get care for your daughter-in-law” “Health providers may have valuable information and skills for pregnancy care” “Your wife and unborn child come first” “You need to take more responsibility/action for wife and unborn child”</p>

Attachment I. Sample Logistics Plan

Cluster 1: Generic BCC Communication

Activity/ Material	Intended TA	Intended User	Total Quantity	Quantity By Region				Quantity in Stock	Quantity Distributed	Quantity to Produce	Distribution Mechanism	Distribution Responsibility
				1	2	3	...					
Poster	Women	Women	10,000	2000	3000	1000	4000	5000	2000	3000	MoH	MNCH Prog.
Brochure	Mothers	S. Children	100,000	5000	8000	7000	6000	50000	30000	20000	MoE	PAIMAN
FlipChart	Women	LHW	12000	2000	1000	500	3000					
Health session	Women											
	& Husbands	LHV/Ser. Prov.	200	20	30	10	40		50	150	MoH	SAVE

Cluster 2: Service Promotion

Activity/ Material	Intended TA	Intended User	Total Quantity	Quantity By Region				Quantity in Stock	Quantity Distributed	Quantity to Produce	Distribution Mechanism	Distribution Responsibility
				1	2	3	...					

Attachment J. Major Players and Programs

The Federal Ministry of Health (MoH) and Provincial Departments of Health (DoH) have been implementing a number of initiatives, which focus on addressing the challenges of maternal and child health. The two major MoH programs are the Lady Health Worker (LHW) Program and the National MNCH Program. The LHW Program has been in existence since 1994, while the more nascent MNCH Program came into being in 2005 to serve as a coordinating mechanism for all existing and futures MNCH matters **a) The National Program for Family Planning and Primary Health Care (also called the Lady Health Workers Program)**

The National Program for Family Planning and Primary Health Care (FP & PHC) was launched in 1994 to address health problems and access issues at the community level, focused on rural and less developed urban areas and a goal of increasing local involvement in decision making. This program introduced the LHW, who, as envisioned, has been providing information and outreach services and delivering quality integrated health service to people's doorsteps. Lauded as "lady soldiers on foot," LHWs serve as agents of change and act as the liaison between the communities and the formal health system (NP for FP&PHC, 2008).

Nearly all LHWs have at least an 8th class education. Each receives 15 months' training and 15 days' refresher training per year. She serves a population of about 1,000 (approx. 200 households) through monthly home visits. Only 35 percent of the population of women she serves is literate. Her own home is designated as a Health House and the health facility in each union council is her focal point. There are about 96,000 LHWs serving close to 100 million people, covering almost all districts (NP for FP&PHC, 2003; Save the Children, 2008b).

Box 1. Profile of a Lady Health Worker's Duties

Outreach

- Organizes the community by developing male and female Health Committees (HC), who assist her with awareness-raising, behavior change and services promotion;
- Educates community members on disease prevention and health-seeking behaviors, e.g., focusing on hygiene, nutrition, sanitation and FP;
- Provides antenatal and postnatal care and advises families on referrals in the case of obstetric- or child-related emergencies, by adhering closely to case management guidelines and coordinating with the nearest health facilities, TBAs/daiyan (i.e. plural of dai) and other SBAs.

Service Delivery

- Provides essential drugs for treatment of minor ailments like diarrhea and minor upper respiratory infections (which account for 60 percent of under-five mortality); and for intestinal worms, iron deficiency and malaria, etc.;
- Provides contraceptive pills, condoms and injectibles to eligible couples;
- Administers vaccines, monitors the tuberculosis DOTS and surveys for detection of polio.

Sources: WHO, 2006; NP for FP and PHC, 2003.

Several evaluations have demonstrated that the LHW Program has been delivering dramatic results. A 2002 external evaluation report conducted by Oxford Policy Management found that most of the health indicators in the population covered by the LHWs were significantly better as compared to the control area. About 40-50 percent of target audiences had received services. It was reported that 20 percent contacted the LHW during an illness and 70 percent in a pregnancy-related or post-natal emergency. These community health workers have contributed to higher childhood immunization rates and CPR; increased provision of iron tablets and in level of child growth monitoring; and an uptake of antenatal services. In fact, in 2001-03, they vaccinated 16 out of 30 million children against polio and 4.5 out of 5 million women against maternal and neonatal tetanus (MNT) (WHO, 2006).

The National Program for RP and PHC reported the success in decreasing MMR and IMR in the LHW catchment areas in 2006 as follows:

Table I. Health Indicators for LHW Catchment Area		
Indicator	National	LHW Catchment Area
Maternal Mortality Ratio (MMR)	340	180
Infant Mortality Rate (IMR)	78	50
Contraceptive Prevalence Rate (CPR)	36%	38%
Tetanus Toxoid Vaccinations (TT2)	51%	57%
Antenatal Care	43%	49%
Skilled Birth Attendance	31%	55%
<i>Source: NP for FP&PHC, 2006.</i>		

The evaluation also found that the program has some key weaknesses that need to be addressed: LHWs were seriously undersupplied with drugs and contraceptives, services were limited in the referral facilities, the Lady Health Supervisors (LHS) needed more support including transportation, and the LHWs needed additional training and skills building. It also recommended targeted recruitment of LHWs from underserved areas to redress the coverage imbalance (OPM, 2002).

b) National Maternal, Newborn and Child Health (MNCH) Program

At the Public Health Forum in April 2005, the MoH commissioned its National MNCH Strategic Framework and created a separate MNCH cell to integrate relevant interventions under one roof and develop it into the lead coordinating body. The framework addresses the need for coherent, innovative, sustainable, reliable and cost-effective services for all at the provincial and district levels, particularly the poor and disadvantaged.

The National MNCH Program is focused on improving access and quality of MNCH and FP services with these key strategies:

- **Strengthen comprehensive and integrated MNCH services at the district level:** Basic and comprehensive EmONC will be ensured at primary facilities and secondary hospitals respectively. Health facilities at all levels will be equipped to provide a comprehensive maternal and newborn health services package. The project will involve more than 7,000 health facilities involving over 15,000 healthcare providers.
- **Introduce a new cadre of community-based SBAs (i.e., Community Midwives (CMWs)).** By 2012, the goal is to have 12,000 internationally certified CMWs trained in home-based deliveries deployed to their catchment area supported by an active transportation/referral service and comprehensive EmONC facilities.
- **Comprehensive FP Services at health facilities:** In collaboration with the Ministry of Population and Welfare (MoPW), all facilities will be equipped to provide a full range of contraceptives and follow-up services. All district and tertiary hospitals, Rural Health Centers (RHCs) and selected BHUs will be strengthened through staff training and improvements in logistics and management systems.
- Increase demand for health services through targeted, socially acceptable communication strategies (see next section).

The program will ensure progress toward improving MNCH with the following targets:

- Reduce the Under-five Mortality Rate to less than 65 per 1000 live births by the year 2012;
- Reduce the NMR to less than 40 per 1000 live births by the year 2012;
- Reduce the IMR to less than 55 per 1000 live births by the year 2012;
- Reduce MMR to 200 per 100,000 live births by the year 2012;
- Reduce the TFR to 3 by 2012;
- Increase CPR to 45 percent by 2012;
- Increase the proportion of deliveries by SBAs to 60 percent by 2012;

-
- Increase the proportion of births in public/private health facilities to 55 percent by 2012;
 - Increase the proportion of pregnant women visiting a health facility for antenatal consultation to 65 percent by 2012.

Source: MNCH, 2006.

2) Other Government Programs

As mentioned in the Preface, a number of vertical programs and projects within the MoH and elsewhere provide critical MNCH services. There is considerable overlap in plans and reach. And current successful collaboration and room for future cooperation exist among all the MNCH-related programs and projects, including with the following:

a) Ministry of Population Welfare (MoPW)

The GoP's goal is to achieve population stabilization by 2020. Although the MOH has substantial responsibility for FP services through its network of public hospitals, RHCs, BHUs and LHWs, the primary responsibility for overseeing and coordinating activities lies with the MoPW. It manages a service network consisting of 263 Reproductive Health Centers, 2740 Family Welfare Centers, and 292 Mobile Service Units, in addition to its Family Welfare Workers and male motivators (Population Council, 2008c).

The 2002 Population Policy is focused on, among others, developing inter-sectoral approaches to service delivery, improving access to and quality of care for clients, improving the status of women, and seeking greater male participation in efforts to achieve better reproductive health. Other ministries focused on education, women's development, religious affairs play supporting roles as well (Population Council, 2008c).

One of its main goals is to reduce the PGR to 1.5 percent by 2012 (MoPW, 2007).

b) Women's Health Project (WHP)

This Asian Development Bank (ADB)-funded project, taken over by the National MNCH Program, has been centered on three components in 20 districts:

- Extend basic health care and FP interventions for underserved populations by using Female Health Workers (FHWs), conducting safe delivery campaigns and promoting women's health (and expanded to newborn health in partnership with Save the Children/Pakistan);
- Develop 20 women-friendly district health systems by strengthening district health management, developing women's health and referral services and mobilizing social support for women's health;
- Support project coordination, capacity building, advocacy, monitoring, evaluation, research, policy development and human resource development.

An internal ADB *Operations Evaluation Report* notes that training institutes were built or renovated and were fully equipped, and short-, medium- and long-term training programs were provided to different categories of health personnel. The project's health facilities resulted in more women making use of maternal care services. The community-based 8,000 FHWs improved the district-level referral network. The information, education and communication (IEC) and behavior change communication (BCC) initiatives as well as health education appear to have raised awareness of women's health issues among women and also among public officials, civil society and communities. The institutionalization of District Health Management Teams in the project districts was a particularly noteworthy achievement, as this encouraged all four provincial governments to replicate the model in other districts as well (ADB, 2008).

c) National Nutrition Program

Its goal is to improve the nutritional status of people in general, with special emphasis on certain sub-groups: women of CBA, adolescent girls and children. The program addresses micronutrient deficiency, which has profound effects on immunity, growth and mental development and may underlie the high burden of morbidity and mortality among women and children.¹

¹ Information on MoH programs (c) through (g) is derived from the MoH Website.

d) National Expanded Program on Immunization (EPI)

It aims to protect children by immunizing them against childhood tuberculosis (TB), poliomyelitis, diphtheria, pertussis, measles, tetanus; and also their mothers against tetanus. Immunization is one of the most cost-effective interventions in preventing communicable diseases, especially in children. The program has been successful in immunization coverage and disease reduction and has developed its own surveillance system, cold chain system, field supervisory and monitoring/evaluation mechanisms. It has received substantial investment from the MoH and development partners, such as UNICEF, World Health Organization (WHO), the Canadian International Cooperation Agency (CIDA), Japanese International Cooperation Agency (JICA) and Save the Children/P.

e) Polio Eradication Initiative

Since the global Polio Eradication Initiative was launched in the late 1980s, the number of cases has fallen by over 99 percent and the number of polio-infected countries was reduced from 125 to 6, of which Pakistan is one. There were 103 confirmed polio cases in Pakistan during 2003. The MoH and WHO concentrate on four strategies to stop the transmission of wild polio virus. These include high infant immunization coverage with four doses of oral polio vaccine in the first year of life; and supplementary doses of oral polio vaccine to all under-five children during Supplemental Immunization Activities (SIAs) for polio.

f) Integrated Management of Childhood Illnesses (IMCI) Strategy

WHO and UNICEF have worked with the MoH since 1998 in implementing a strategy called Integrated Management of Childhood Illness (IMCI), which is an approach to child health that focuses on the well-being of the whole child and takes into account the variety of factors that put children at serious risk. It ensures the combined treatment of major childhood illnesses, emphasizing prevention of disease through immunization and improved nutrition.

g) Acute Respiratory Infections (ARI) Control Project

Studies have reported that child mortality due to ARIs could be reduced by one-half if early detection and appropriate treatment were provided. To address this, the WHO-initiated program focuses on simple case management procedures that have been designed for diagnosis and treatment in situations without any laboratory and radiological facilities.

h) Reproductive Health Project

This ADB-funded project is expanding the GoP's family planning and maternal and child health services in 34 poorest and underserved districts in the four provinces of Punjab, Sindh, North-West Frontier Province (NWFP), and Balochistan. These services will be integrated into a modern reproductive health approach that is expected to be more acceptable and have more impact under devolution and with strong community participation. It promotes reproductive health through targeted information campaigns.

3) Partnership with the United Nations

The GoP, through the MoH and other ministries, coordinates with the UN on many levels according to its Country Cooperation Strategies with separate agencies under the auspices of the Inter-Agency Coordination Committee, which provides a forum for donor coordination.

a) World Health Organization (WHO)

In addition to extensive aforementioned contributions, in 2000-01 WHO worked with the GoP to devise an integration strategy for the different public health programs into PHC—such as malaria and TB control, MCH/FP, EPI, ARI, the Control of Diarrhoeal Disease (CDD). WHO continues to focus on integrated management through health policy and system development; strategic planning at the district level; quality assurance and adequate and balanced health coverage; protection against communicable and non-communicable diseases; and healthy lifestyle promotion.

b) UNICEF

Since 2004, UNICEF has supported the GoP through its **Promotion of Safe Delivery Practices**. It conducted formative research in 2005 to test the acceptability of CMWs in two pilot areas in Sindh. It found that the concept of a CMW is generally acceptable to married women, their

husbands and community influentials if it is convenient and not too costly. The mothers-in-law are least amenable. Respondents indicated that a midwife would be accepted gradually *only* if she was from the community and had requisite medicine and equipment. UNICEF-trained midwives felt it would take 1-4 years to be accepted in the community. Their constraints were reported as lack of facilities at the household level, lack of awareness in community about skilled versus unskilled and their need for a regular source of income. The midwives and communities agreed that all three should collaborate and coordinate, with the LHW introducing the CMW to households and the CMW sharing the work and fee by employing the TBA/*dai* as her assistant (UNICEF, 2008a).

About 70 health facilities have been upgraded to provide EmONC services in 11 districts, many providing 24-hour services. Seventy-four CMWs in three districts have completed their 18-month training to learn how to safely and expertly attend childbirth, monitor women for signs of complications and refer them to hospitals if necessary. Each is now back in her home village in a UNICEF-supported Midwifery Home. More than 60 percent of all deliveries are conducted by a SBA in nine of eleven focus districts, compared to the national average of 39 percent (UNICEF, 2008b).

Related to **Community-based Nutrition and Breastfeeding**, UNICEF has been distributing integrated packages, which includes information on infant feeding, to emergency obstetric care centers. To address malnutrition, UNICEF, the MoH, the Micronutrient Initiative and the World Food Program have developed a national action plan and communication strategy on promoting iodized salt.

c) UNFPA

UNFPA's aim with **Promoting Interventions for Safe Motherhood** is to provide voluntary FP to reduce unwanted pregnancies and to ensure that all women have the assistance of a skilled health worker during pregnancy and delivery, and access to emergency medical care if complications arise. UNFPA-supported programs in Pakistan also emphasize technical and managerial capacity development in maternal care, especially strengthening LHW supervision and harmonizing management information systems (MIS) at the district level. In order to enhance visible and continued commitment, UNFPA has focused on strengthening national advocacy campaigns on population and development issues by targeting policy planners at all levels and trying to improve widespread understanding and support through accurate media portrayal and promotional events. The MoPW is to assume the lead advocacy role (UNFPA, 2003).

4) Donor Funded Projects

The Poverty Reduction Strategy Paper (PRSP) has been adopted for aid efforts, including health, and once again, the Inter-Agency Coordination Committee serves to optimize the bilateral aid flow according.

a) Pakistan Initiative for Mothers and Newborns (PAIMAN)

Within the safe motherhood community, a consensus has emerged that in order to reduce maternal mortality, programs should focus on birth and the immediate postpartum period, during which the risks to the mother and the newborn are the highest as life-threatening obstetric complications can be unforeseeable and sudden.

PAIMAN is a five-year project (2005-09) funded by the US Agency for International Development (USAID), which has been assisting the MOH with multi-pronged and integrated strategic approach that combines individual health care with public health and community-based interventions in 11 districts, two FATA Agencies and two Frontier Regions, benefiting 2.8 million married couples and 420,000 newborns (USAID, 2008). Its objectives have focused on both demand- and supply-side factors along the continuum of health care for women from the home to the hospital:

- Increase awareness and promote positive health-seeking behaviors;
- Increase access to and community involvement in MNCH services, including EmONC;
- Improve integrated quality services, particularly related to the management of obstetrical and neonatal complications;
- Increase capacity of MNH managers and providers with training and continuing education.

PAIMAN's strategic framework follows a series of steps necessary to increase the likelihood of survival of a mother and her newborn in the event of complication or illness. The project has also been renovating and equipping facilities and has trained doctors and LHWs to manage pregnancy-related emergencies and is helping build the new cadre of community midwives in response to the long-term goal of skilled birth attendance for all deliveries (PAIMAN, 2008a).

Box2. PAIMAN Formative Research Findings

To increase awareness and promote positive MNH behaviors, PAIMAN has implemented an NGO sub-grants mechanism to develop community-based plans. Through these local grants, the project recruited and trained Community Health Workers in villages that are not covered by LHWs to empower women and the community members to learn about healthy practices and take responsibility for good health. Awareness-raising was conducted through health groups, theatre, celebrations, events and other types of meetings. A 2008 assessment found that beliefs, attitudes and knowledge among married women surveyed about MNH has improved over time. There were still knowledge gaps, especially in the areas of postnatal and newborn care. And women's knowledge about danger signs during all stages of pregnancy, breastfeeding practices and delaying first bath needs to be enhanced (Population Council, 2008a).

From the September 2005-May 2006 formative research, findings indicated that LHWs were not being utilized as optimally as they could be due to community members' lack of trust, inadequate supplies or their limited knowledge. The LHWs were mostly treating minor illnesses, advising on newborn care and arranging vaccinations. Feedback indicated that they need some additional interpersonal (IP) communication training in counseling on topics such as FP, diet and rest, appropriate workload, nutrition, birth preparedness and postpartum checkups.

Researchers also recommended that the TBAs/daiyan be integrated onto the team rather than trying to undercut her presence. Establishing a system by which the dai does not lose her income and credibility in the community involves identifying and designing ways for the TBAs and other providers to work in close contact, e.g., train daiyan in hygienic practices, basic first aid and MNH protocols. Also planners should seek to motivate daiyan to increase their knowledge and skills (PAIMAN, 2006a and 2006b).

Some suggested messages:

- Highlight pregnancy as a special time deserving unique attention to encourage prompt care;
- Distinguish between general illness and signs and symptoms of pregnancy;
- Increase knowledge about normal labor and high risk delivery;
- Increase awareness about life-threatening conditions for mother and child and early interventions during pregnancy and delivery;
- Designate family and community roles and responsibilities in obstetric emergencies and clarify them to both the providers and the beneficiaries;
- Position the postpartum period as a part of the pregnancy cycle.

Source: PAIMAN, 2008a.

The PAIMAN consortium, led by John Snow Inc. (JSI), comprises the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP); Mercy Corps; the Pakistan Voluntary Health and Nutrition Association (PAVHNA) and Save the Children, US (PAIMAN 2008a).

b) Family Advancement for Life and Health (FALAH)

In the past, FP programs had an emphasis on family limitation over birth spacing. However, recent policy changes encourage women to use FP to improve maternal health by increasing the interval between two births. Since at least a quarter of women in Pakistan want to avoid further childbearing or postpone their next child for at least 2 years but are not using a method of contraception, the challenge is to ensure continuous use by current users and increase existing CPR by meeting the unmet need for FP services.

Research has also demonstrated that children born too close to a previous birth are at increased risk of dying. In Pakistan, one-third of births occur less than 24 months after a previous birth, the same proportion as in 1990-91. The under-five mortality rate is twice as high for children born after an interval of less than 2 years, compared with those born four or more years after a previous sibling (122 vs. 61 deaths per 1,000 live births). [DHS]

FALAH is a five-year USAID-funded project (2007-2012) whose goal is to increase the use of FP and birth spacing in 20 underserved districts by removing barriers and expanding access to services while improving understanding of the value of FP for family health and well-being by. Its objectives are as follows:

- Increase demand for and practice of birth spacing;
- Increase access and quality of FP services in the public sector and coverage and quality in the private sector;
- Increase the coverage of contraceptive social marketing and provide marketing support to the commercial sector to strengthen contraceptive security.

The FALAH consortium, led by the Population Council, comprises JHPIEGO, Greenstar Social Marketing, Health Nutrition and Development Society (HANDS), Mercy Corps, Rural Support Programme Network (RSPN) and Save the Children, US.

Sources: Population Council, 2008c and 2008d.

c) Primary Health Care Revitalization, Integration and Decentralization in Earthquake- affected Areas (PRIDE)

This four-year project (2006-1010) is the health component of USAID's reconstruction and rehabilitation program in Mansehra (NWFP) and Bagh Districts (Azad Kashmir). PRIDE's scope is the following:

- Strengthen the financial and human resource management capacities of district health authorities and PHC providers;
- Improve access to and quality of PHC services through an essential package of health services and improved skills of PHC personnel;
- Increase community demand for quality services through an innovative social mobilization process aimed at increasing knowledge for informed decision-making.

The project empowers front-line health workers by designing and implementing simple, low-cost, hands-on solutions that strengthen the delivery of health care services, following the household-to-hospital continuum of care. It also partners with community- to national-level organizations to build sustainable, local capacity through advocacy and policy and guidelines development. PRIDE has recently developed a communication and marketing strategy as well.

The PRIDE consortium is headed by the International Rescue Committee (IRC) and is comprised of Management Systems for Health (MSH), [JHPIEGO](#) and the [Population Council](#)

Source: PRIDE, 2008

d) Pakistan Health Systems Strengthening Project now known as Technical Assistance for Capacity Building in Midwifery, Information and Logistics (TACMIL)

This two-year project focuses on areas which are critical to operational strengthening of health systems in Pakistan. TACMIL provides technical assistance to the public and private health sector to improve health service delivery with a focus on maternal, reproductive and child health. The project has four components: Capacity building of nursing and midwifery organizations by improving the skills and competencies of midwifery tutors and staff at clinical practice sites, while building the management effectiveness and financial sustainability of regulatory institutions and professional organizations,

primarily Midwifery Association of Pakistan (MAP) and Pakistan Nursing Council (PNC); Raising citizen's awareness and encourage them to hold government administrations accountable for providing quality health services by applying modern approaches to communication and information dissemination. This includes awareness raising and information sharing by disseminating results of Pakistan Demographic and Health Survey through National Institute of Population Studies (NIPS) to a wider range of audience including health managers and policy makers, and training of journalists in utilizing health data for reporting and raising community awareness; implementing innovative solutions through a small grants program for local NGOs in project's districts in order to strengthening health care delivery and district management systems; strengthening logistics management and information systems for contraceptives and essential drugs at districts, provincials and the federal levels.

Abt Associates works through various national and international organizations for implementing TACMIL in 20 districts of the country, that include: AASA Consulting (now known as Access Consulting), Banyan Global, American College of Nurse Midwives (ACNM), Internews, Logistics Management Institute (LMI) and Union Transport Incorporates (UTi).

Source: Abt Associates, 2008.

e) Norway-Pakistan Partnership Initiative (NPPI)

This five-year project (2008-2012) is designed to provide catalytic support for national, provincial and district plans to improve provision of and access to MNCH interventions. It also aims to raise demand and utilization for those services in ten rural under-served districts in Sindh Province selected for their prevailing high mortality rates. Working jointly with Government Programs (MNCH, LHW and National Nutrition), UNICEF, WHO and UNFPA. Its priority areas are in sync with the National MNCH Program include the following:

- Skilled birth attendance, in particular CMWs and EmONC;
- Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and improved nutritional status of mothers and children;
- Operational research and M&E systems;
- Community-based interventions and public-private partnerships;
- District health systems reforms and defining the roles of the federal, provincial and district governments;
- Public sector institutional strengthening through improved management and governance.

Source: MoH and NPPI, 2008.

e) The UK Department for International Development of the UK (DfID)

The UK Department for International Development (DfID) has a ten-year Development Partnership Agreement with Pakistan and provides a great deal of budgetary support. It has recently pledged to double its aid for the period 2008-2011 to 480 million pounds (approx. US\$688 million). It is currently increasing funding for Polio Immunization Days and is supporting a Community Midwifery School in NWFP in the Nowshera District (DfID, 2008).

5) Partnership with NGOs

a) Save the Children's Saving Newborn Lives (SNL) - 2

Preventing neonatal deaths has been neglected in both child survival and safe motherhood programs in the past. These programs have mostly focused on preventing infant and child deaths from pneumonia, diarrhea, and vaccine preventable diseases, which are important causes of death that can occur, but do so after the first month of life. Reducing deaths in the first week of life by at least half will be essential for progress toward MDG-4.

Since 2000, Save the Children has been working with the MoH through SNL-1, which focused on essential newborn care and maternal and child tetanus (see *next program*). In 2006, Saving Newborn Lives (SNL) 2 was launched to scale up evidence-based newborn care interventions and approaches that directly address the major causes of newborn illnesses and death. This includes developing strategies and tools to reduce high rates of neonatal death and the development of community-based

strategies to increase adoption and use of life-saving newborn health interventions. Specific objectives are as follows:

- Through research, develop and validate new and improved approaches that address key demand- and supply-related barriers to reducing newborn deaths in three priority areas;
- Test integrated packages of newborn health interventions to demonstrate their cost-effectiveness in reducing mortality in representative low-resource settings;
- Show best practices for integrating newborn health into MCH policies and programs and ways to overcome constraints, including adapting packages to various delivery systems;
- Determine ways to overcome policy barriers for integrating programming at scale, and promote effective tactics for varying health systems and policy and resource environments.

Source: Save the Children, 2008a

The three priority areas for the second phase of SNL are as follows:

- **Neonatal infections.** They account for about 20 percent of neonatal deaths. Given the prevalence of home deliveries by untrained TBAs, referral and treatment options are needed.
- **Birth asphyxia.** This contributes to some 40 percent of deaths. No standard protocol exists for community-level birth attendants, and LHWs lack practical experience in this area.
- **Preterm/Low Weight Birth (LBW).** Contrary to expectations, the proportion of such LBW babies reported by the mother has increased from 22 percent in 1990- 91 to 31 percent in 2006-07. Children whose birth size is small or very small have a 68 percent greater risk of dying before their first birthday than those whose birth size is average or larger.

Source: Pakistan Demographic and Health Survey 2006-07

Box 3. Formative Research on Infections, Birth Asphyxia and Low Birth Weight

Recent formative research data from studies on these three conditions conducted by Arjumand and Associates for Save the Children reveal a number of important findings:

Neonatal Infections

- TBAs understand the need for cleanliness and understand that dirt and filth cause infections, but lack understanding about what exactly constitutes clean and safe delivery practices.
- Some daiyan are washing their hands and using safe birth kits.
- TBAs generally lack knowledge about danger signs.
- Misconceptions exist about the benefits and importance of TT injections; most women are not sure about number or timing; and some fear that injections may cause abortion.
- Traditional home remedies for treating infections are not thought to be dangerous. The application of ineffective or potentially dangerous mixtures is commonplace.

Birth Asphyxia

- Mothers and daiyan don't have clear idea about the normal duration of labor pains.
- Prolonged labor is considered harmful.
- Many believe that "blue baby" is the result of evil eye and needs faith healing.

Preterm/Low Birth Weight

- Mothers do not know how much babies should weigh but are aware that they get weighed at health facilities.
- Appearance is the means by which most women and daiyan judge.
- Low birth weight is not considered a reason to seek a health provider.
- Misconceptions about reasons for low birth weight include superstitions like the evil eye.
- Various misconceptions about diet, warmth and bathing of a newborn exist.
- Diet of breastfeeding mother is regarded as important.

Source:AAA, 2008.

Similar to the PAIMAN study, the Arjumand and Associates (AAA) findings revealed that LHWs are underutilized. Responses provided a mixed picture, with the following being among the prejudices against them:

- LHWs only provide FP services and polio drops.
- They use low-quality or contraceptive-laced medicines.
- Most pregnant women and their families did not object to their presence during delivery, but did not consider them as necessary.

On the part of LHWs, they indicated that they are not inclined to care for newborns unless their salaries are raised.

Box4. Aga Khan University/Save the Children Hala Study on the Effectiveness of LHWs

Because there were few studies to evaluate the effectiveness of LHWs in addressing perinatal and newborn care in rural areas, the five-year Hala study was conducted in the Matiari District of Sindh by Aga Khan University (AKU) and Save the Children/P. It was designed to evaluate the effectiveness of a community-based package of interventions by LHWs (who were trained by the National Program for FP and PHC and AKU) to improve delivery conditions and reduce neonatal mortality in ordinary health system settings.

The interventions focused on training LHWs in briefing mothers about simple newborn health care measures; and on setting up community HCs to educate fathers about health care for mothers and newborn babies.

The recently released results revealed that using low-cost programs—like the LHW Program—that can be implemented within the framework of the existing health care system can be highly effective. A substantial reduction in the overall rate of stillbirths and neonatal mortality was recorded in the areas with LHW involvement:

- Mothers feeding their babies colostrum increased from 46 percent to 95 percent;
- Delaying newborn bathing increased from 26 percent to 57 percent;
- Home births decreased from 53 percent to 32 percent;
- Births at health care institutions increased from 40 percent to 67 percent.

Source: AKU, 2008

Similar upcoming research projects will evaluate the effectiveness of training LHWs in preventing and treating birth asphyxia, newborn infections and low birth weight.

b) Maintaining Tetanus Elimination Status in Pakistan

The 2001-03 maternal and neonatal tetanus (MNT) campaign undertaken by the MoH, Save the Children, UNICEF, CIDA and JICA was a great success. The combination of vaccination coverage and continuous support to safe delivery and cord care programs in high risk-areas of selected districts, in conjunction with social mobilization and awareness campaigns, was very effective. A decline in the tetanus-related NMR was recorded from 28 percent to 14 percent, through campaigns that reached 11.1 million and 10.2 million women of CBA with TT1 and TT3 immunization coverage respectively (88 percent and 89 percent of the target populations). Two critical components were the LHWs as vaccinators and the quality formative research at the community level that informed the highly successful communication and advocacy campaign and LHW door-to-door implementation strategy.

The current PDHS reports that only 1 percent of neonatal deaths are attributable to tetanus. But once tetanus is eliminated, it needs to be maintained. The essential service delivery components of maintaining/sustaining elimination status are as follows:

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- Strengthen the *routine* TT vaccination to ensure benefits of high risk-area approach;
 - Promotion of access to safe/clean delivery services/practices;
 - Promotion of access to proper/safe cord care practices.

Differentials in EPI coverage and clean/safe practices at provincial and district levels will be addressed in this next phase of maintaining tetanus elimination. Populations with poor access include segments living in peri-urban, but marginalized areas (e.g., slum dwellers) and remote or nomadic populations with no services close to localities. Psychosocial barriers and attitudes that inhibit acceptance of services and lead to inadequate participation (i.e., drop-outs) need to be addressed as well. Weaknesses in EPI services in remote static facilities related to absence of staff, lack of cold chain equipment, or supplies of vaccine/syringe and functionality of static centers need to be remedied.

Save the Children/P developed and piloted a model in seven districts of NWFP in May 2008 with UNICEF support for training. The EPI and NP for FP and PHC Programs are working together to scale up the routine EPI activities in other provinces focusing only on child vaccination. Key elements will include Standard Operating Procedures, a uniform training manual and plan to prepare LHWs to be responsible for 100 percent immunization coverage. LHWs have been receiving IP training on simple messages about the “three cleans” and TT as part of antenatal care.

Source: Ahmed & Ikram, 2008.



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