Center for Communication Programs

JSI Research & Training Institute, Inc.

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PAIMAN

Communication, Advocacy and Mobilization Strategy

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Pakistan Initiative for Mothers and Newborns

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Abbreviations

AMTSL	Active Management Of Third Stage Labor
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BF	Breastfeeding
BP	Birth Preparedness
CAM	Communication, Advocacy and Mobilization
CBO	Community-based Organization
CCP	Center for Communication Programs
CDK	Clean Delivery Kit
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CMO	Community Mobilization Officer
CMWRA	Currently-Married Women of Reproductive Age
CPR	Contraceptive Prevalence Rate
DCO	District Coordination Officer
D. G. Khan	Dera Ghazi Khan
DHIS	District Health Information System
DHMT	District Health Management Team
EDO	Executive District Officer
EMNC	Essential Maternal and Neonatal Care
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Program on Immunization
EPI-MIS	Expanded Program on Immunization-Management Information System
FP	Family Planning
GDP	Gross Domestic Product
GOP	Government of Pakistan
HC	Health Committee
HCP	Healthcare Provider
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information, Education and Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPC	Interpersonal Contact
IP&C	Infection Prevention and Control
JSI	JSI Research and Training Institute, Inc.
LHV	Lady Health Visitor
LHW	Lady Health Worker
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health

MO	Medical Officer
MOH	Ministry of Health
MOPH	Ministry of Population Welfare
NGO	Nongovernmental Organization
NIPS	National Institute for Population Studies
NWFP	North-West Frontier Province
ORS	Oral Rehydration Salts
PAIMAN	Pakistan Initiative for Mothers and Newborns
PAVHNA	Pakistan Voluntary Health & Nutrition Association
PDHS	Pakistan Demographic and Health Survey
SBA	Skilled Birth Attendant
SC/US	Save the Children/USA
SO	Strategic Objective
TBA	Traditional Birth Attendant
ToT	Training of Trainers
TV	Television
USAID	United States Agency for International Development
WMO	Woman Medical Officer

Communication, Advocacy and Mobilization Strategy

Introduction

Pakistan Initiative for Mothers and Newborns (PAIMAN) is a six-year United States Agency for International Development (USAID) funded project designed to reduce Pakistan's maternal, neonatal, and child mortality. PAIMAN strives to 1) Ensure women have access to skilled birth attendants (SBAs) during childbirth and throughout the postpartum period as well as access to family planning (FP) services, 2) Ensure newborns and children under 5 years of age are well-nourished and protected from and treated for waterborne and other infectious diseases, and, 3) Foster adherence to Integrated Management of Neonatal and Childhood Illnesses (IMNCI) guidelines for childhood development. PAIMAN works at national, provincial and district levels to strengthen public and private healthcare provider (HCP) capacity and improve health system infrastructure. Its community-based approach provides continuum of care to mothers, newborns, and children through supportive linkages, from home healthcare to hospital-based care.

PAIMAN's vision is fully aligned with that of the Government of Pakistan's (GOP) National Maternal, Newborn and Child Health (MNCH) Program. It believes success in improving mothers', newborns' and children's health rests with recognizing and acknowledging access to essential healthcare as a basic human right in a society in which women and children enjoy the highest levels of health and where no family suffers loss of mother or child due to preventable or treatable causes. It further pledges to ensure availability of high-quality MNCH services to all, especially the poor and disadvantaged.

Launched in 2004 for a period of five years and focused on maternal and newborn health in ten districts, PAIMAN received in 2008, a one-year extension, through September 2010, to include 14 new districts and tribal areas. In addition to two tribal agencies, PAIMAN currently operates in 24 districts in all regions, including Azad Jammu and Kashmir. Besides the geographic expansion,

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PAIMAN now includes child health and FP in addition to maternal and newborn health. PAIMAN's key partners are GOP Ministries of Health (MOH) and Population Welfare (MOPW), Provincial Health and Population Welfare Departments, private sector, and consortium partners. Led by John Snow Research and Training Institute, Inc. (JSI), the Project is implemented with a consortium of agencies, including Aga Khan University, Contech International, Johns Hopkins Bloomberg School of Public Health—Center for Communication Programs (CCP), Population Council, and Save the Children USA (SC/US). PAIMAN's original phase also included Greenstar Social Marketing, Pakistan Voluntary Health & Nutrition Association (PAVHNA) and Mercy Corps.

PAIMAN's goals are:

- To strengthen capacity of public and private HCP.
- To improve health care infrastructure.
- To improve care-seeking behaviors at household and community levels.
- To strengthen health systems and integrate MOH and MOPW services.

PAIMAN's strategic framework supports the pathway to care and survival through five strategic objectives (SOs):

SO-1 To increase awareness and promote positive MNCH behaviors.

SO-2 To increase access to and community involvement in MNCH services, including emergency obstetric and newborn care, and to ensure services are delivered through appropriate health and auxiliary health services.

SO-3 To improve public and private sector service quality, particularly in management of obstetrical and neonatal complications.

SO-4 To increase MNCH and FP capacity of managers and HCP.

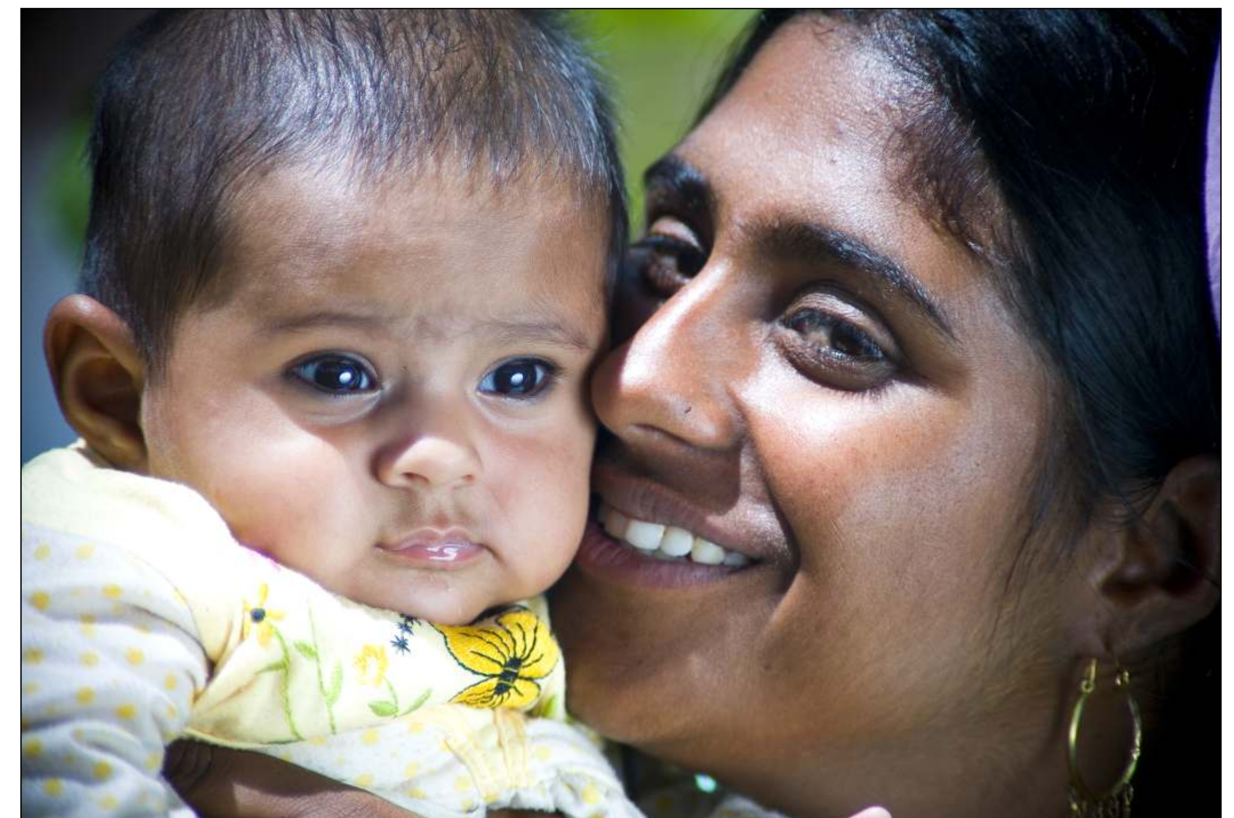
SO-5 To improve management and integration of services at all levels.

Behavior change communication (BCC), referred to as PAIMAN's Communication, Advocacy, and Mobilization (CAM) component, is a cross-cutting function. Although CAM focuses primarily on SO-1 and SO-2, messages, audience objectives and underlying behavioral and attitudinal issues relate to all SOs.

At PAIMAN onset, CCP formed a Thematic Group on Communication with participation from consortium partners. Its purposes were to guide development of an umbrella communication strategy for PAIMAN and to provide strategic input to key CAM initiatives. It supported development of *PAIMAN CAM Roadmap*, the first edition of the communication strategy, widely used by program planners and partner organizations to understand and use key messages, objectives, and channels for PAIMAN audiences.

In light of research findings by PAIMAN partners, including CCP and Population Council, the *CAM Roadmap* was revised and renamed *PAIMAN Communication, Advocacy and Mobilization Strategy*. Its 2006 adoption by MOH National MNCH Program as part of its National MNCH-Planning Commission-1 provided wider acceptance and ensured country-wide rather than selected-district implementation.

This third *PAIMAN CAM Strategy* edition focuses on PAIMAN's expanded scope of work to include child health and FP in programmatic interventions, as well as geographic expansion into 14 additional districts. Also incorporated are lessons learned from more than four years of implementation and reviews of current literature on global MNCH and FP best practices.



Current Situation

Pakistan endures high rates of maternal, newborn, and child mortality and morbidity due to unequal access to quality services, low demand for quality services where they do exist, and high demand for unskilled providers such as traditional birth attendants (TBAs). While major differences in knowledge, attitudes and behaviors related to MNCH exist across Pakistan, significant opportunities for improvement across all regions and communities persist. Understanding the key issues and areas for improvement are the initial steps to designing effective CAM initiatives.

The following review of available literature provides an important summary of the current situation for each health area.

Maternal Health: Pregnancy and childbirth complications emerge as outstanding causes of death in reproductive years, accounting for one-fifth of deaths of Pakistan's women of childbearing age. Although lower than in earlier reports, the 276 maternal deaths per 100,000 births measured by the Pakistan Demographic and Health Survey (PDHS) of 2006-07 showed marked differences between urban and rural areas. Women, families and birth attendants continue to report low levels of awareness regarding danger signs, leading to delays in seeking care when complications arise. Use of SBAs is very low; more than 65% of women deliver at home and less than two-fifths (39%) of births occur with the assistance of a skilled medical provider (doctor, nurse, midwife, or Lady Health Visitor). TBAs administer more than half (52%) of all deliveries. In rural areas, about one in five women make the recommended four or more antenatal visits with a skilled provider. Postpartum care is virtually nonexistent, yet the majority of maternal deaths occur in the first six hours following birth.

Neonatal Health: Infant mortality rate of 78 deaths per 1,000 live births has not dropped appreciably since a dip in the late 1990s. Few women, families, or birth attendants are aware of newborn complications such as fever, respiratory problems, prematurity and cord infection. Rather, the widespread perception is *nothing can go wrong with a newborn*. There is limited uptake of protective home-based practices such as breastfeeding (BF). For example, the majority of Pakistan's newborns are breastfed, but rate of exclusive BF is a mere 55% at two months and 37% at six months. Early weaning and poor feeding practices expose babies to contaminated food and water, contributing to the high burden of diarrheal disease.

Child Health: In the past 16 years, mortality dropped 20% among children under 5 years of age, to 94 deaths per 1,000 live births. Diarrhea and pneumonia are the leading causes of deaths in this age group. The PDHS reported one in three mothers still curtail fluid intake for a child with diarrhea, a dangerous practice that must be addressed. Knowledge of danger signs and care seeking for pneumonia are presumed to be low. In all provinces except Punjab, the majority of children are not fully immunized. In Balochistan, 29% have received no vaccinations. Measles remains endemic as an estimated 21,000 children die every year from measles and its complications.

Family Planning: Although substantial gains in contraceptive prevalence rate (CPR) occurred in recent years, Pakistan continues to experience a high total fertility rate of 4.1 births. Rate of modern method of FP is 22%. Unmet need remains high, as one in four couples report either wanting to limit or space children. Inability to regulate fertility places both mother and child at risk; association between short birth intervals and under-5 mortality is widely documented. Pregnancy at early or late ages and high levels of parity increase women's risk of poor health outcomes.

Cross-cutting Issues: A number of cross-cutting issues affect women's and children's health. Women's low status affects every aspect of life, from birth to death. Many traditional social values discriminate against women, affecting their food intake, nutrition, education, decision-making, physical mobility and health.

Husbands, in-laws, religious and community leaders all play significant roles. A 2001 Hashim and Midhet study of 7,000 married women in the rural district of Khuzdar, Balochistan, found

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nine of ten require their husband's permission in order to be taken to a hospital for treatment of a pregnancy-related complication. Despite consistently reporting that pregnancy and childbirth are female domains, almost universally, men decide the course of action during delivery and postpartum period.

Widespread perceptions, such as illness is caused by supernatural, rather than biomedical, agents, negatively impact utilization of facility-based care for mothers and children. In Pakistani culture, maternal complications arising during postpartum period are attributed to *nazar* (evil spirits). Such beliefs play a dominant role in birth preparedness (BP) and decision-making regarding care seeking.

Pakistan's extensive three-tiered network of public sector health facilities are comprised of primary/basic health facilities, secondary care hospitals, and tertiary teaching hospitals. Despite this, public health facilities are utilized by only about 30% of the population. The remaining 70% is served by the private sector, mainly for curative services. An important service provider in isolated rural communities, the public sector must improve physical infrastructure, safe water supply, privacy for female clients, regular supply of drugs, logistics/equipment and provider capabilities. Immense challenges include addressing the dual need for increased awareness of positive MNCH behaviors with increased access to timely, quality care.

Current Initiatives and Achievements

As a signatory to achieving the Millennium Development Goals (MDGs) of reduction in maternal mortality ratio by three-quarters by 2015, the GOP made maternal and neonatal health its top priority. MOH adopted the National Maternal and Newborn Health (MNH) Strategic Framework and created an integrated Maternal, Newborn and Child Health (MNCH) Program.

The United Kingdom's Department for International Development also funds a major MNH Program for NWFP and Punjab. In addition, aiming to create women-friendly districts through a health system-strengthening approach, Asian Development Bank funded the Women's Health Project in 20 districts and a reproductive health project in 34 districts. PAIMAN works closely with these partners and others to achieve the shared goal of improved MNCH.

Much has been achieved under PAIMAN. During the past four plus years, consortium partners and National MNCH Program collaboratively improved quality and availability of MNCH services in PAIMAN districts and therein promoted positive behaviors. Main accomplishments, up till June 2009, by each SO is as follows:

Main SO-1 accomplishments:

- An estimated 3.1 million beneficiaries reached through interpersonal communication and group counseling interventions.
- ? Nearly 8,500 Lady Health Workers (LHWs) trained in communication skills and support group methodology, empowering them to create 34,000 support groups of 1.5 million members.
- ? An estimated 10 million currently-married women in reproductive age (CMWRAs) reached through a 13-episode drama series, five television (TV) commercials, and a music video.
- ? More than 40,000 people reached through innovative media (puppet and mobile TV shows).
- ? More than 700 *ulama* and 300 journalists trained

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and participating in PAIMAN's comprehensive community mobilization network.

- ? 4,617 district assembly members and school teachers reached through special seminars.
- ? Nearly 10 million men and women reached through 308 local events and theater performances.

Main SO2 accomplishments:

- In 10 districts, 22 midwifery schools and 14 training centers upgraded.
- ? In 14 districts, 50 health facilities, 15 training centers, and seven midwifery schools being upgraded.
- ? Up to 1,600 community-based midwives enrolled in standardized 18-month course, with 110 certified and being placed in midwife homes.
- ? 550 existing midwives trained during four-week competency-based refresher course.
- ? About 100,000 Clean Delivery Kits (CDKs) distributed and sold.
- ? Nearly 1,900 TBAs orientated on clean delivery practices, early recognition of danger signs, and referrals.
- ? 31 health facilities upgraded to provide continuous care.
- ? About 65,000 beneficiaries reached through 3,000 Clinic *Sahoolats*, free clinic days conducted by private providers at their outlets.
- ? 37 local NGOs awarded sub-grants totaling nearly US$6 million to work in non-LHW areas.
- ? Additional 33 local NGOs selected for sub-grants in the new districts.

Main SO-3 accomplishments:

- ? In the private sector, 50 clinics providing comprehensive emergency obstetric and neonatal care (CEmONC) and 569 clinics providing basic Emergency Obstetric and Neonatal Care (EmONC) were franchised under the brand name GoodLife.
- ? 45 Well Baby Clinics established at selected health facilities.
- ? Nearly 11,000 LHWs undergoing training in community-integrated management of neonatal and childhood illnesses (IMNCI).
- ? Districts supported in preparing and implementing infection prevention and control (IP&C) plans at all selected facilities.

Main SO-4 accomplishments:

- 2,200 HCP trained in emergency maternal and neonatal care (EMNC), 73 trained in EmONC, and 73 trained in comprehensive emergency and neonatal care (CEmONC).
- Nearly 8,500 LHWs trained in communication skills and support group methodology, with training underway for additional 2,500 LHWs.
- Health providers trained in active management of third stage labor (AMTSL) and partograph use, essential surgical skills, and client-centered approach for reproductive health.

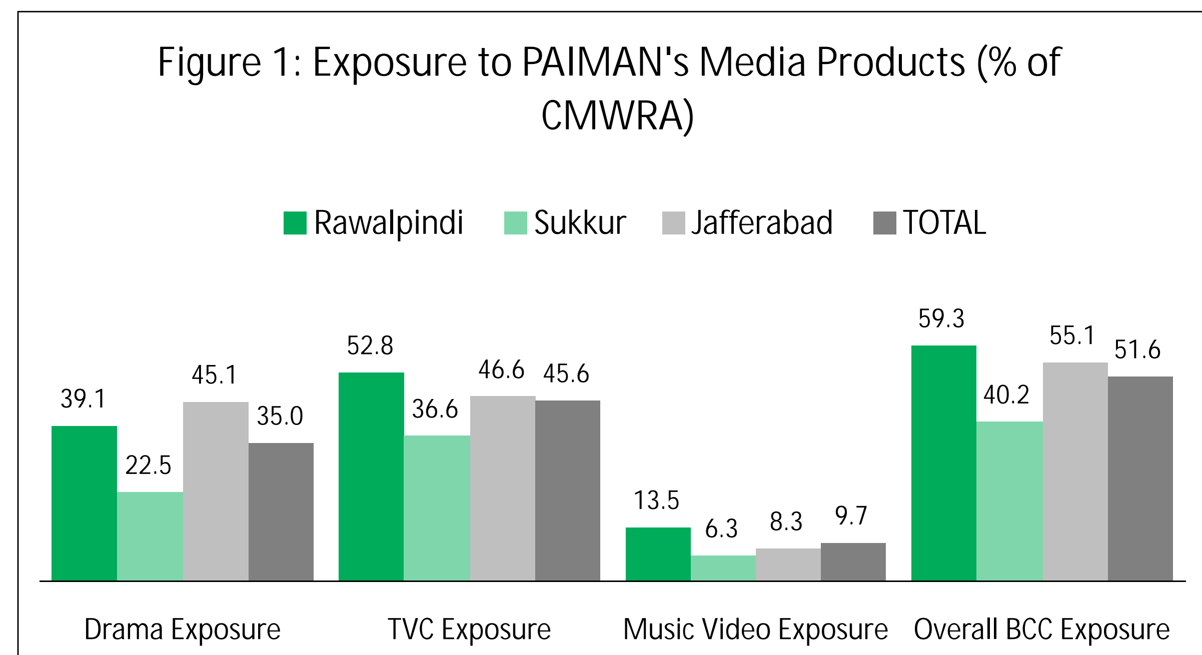
Main SO-5 accomplishments:

- 23 District Health Management Teams (DHMTs) formed, with 10 fully functioning and 13 in start-up mode.
- 100 health managers from DHMTs trained in finance, logistics, human resources, and supportive supervision.
- 2 management software packages created and distributed, with support and training to facilitate development of financial management and district annual operational plans.
- MOH staff supported in implementation of District Health Information System (DHIS).

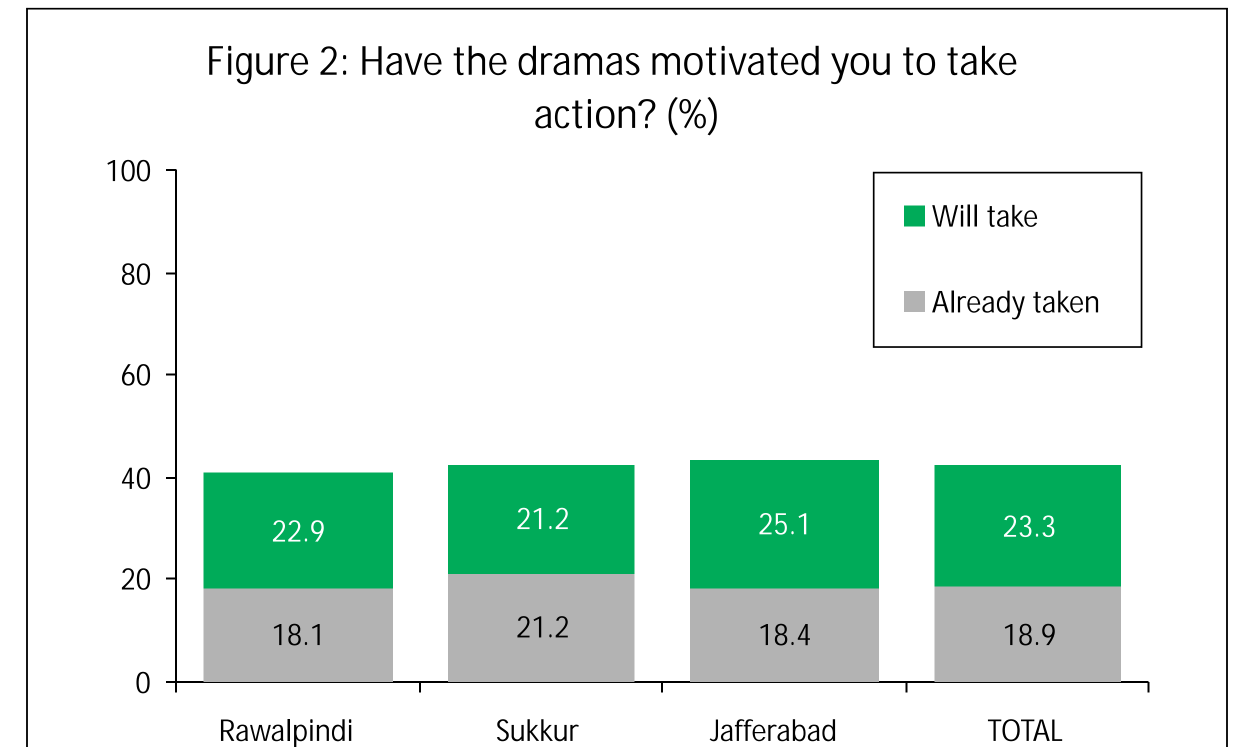
BCC Impact Evaluation Key Findings

Impact evaluation of PAIMAN BCC component, specifically mass media activities (TV drama series, TV spots, music video), was conducted in Rawalpindi, Sukkur, and Jafferabad Districts. The sample included 1,894 currently-married women of reproductive age (CMWRA), 630 husbands, and 630 mothers-in-law. Housewives comprised 89% of CMWRA. Of them, 90% had living children. A little more than half reported at least some education.

Regarding exposure to BCC activities, 52% of the CMWRA had seen at least one component, with a quarter reporting exposure to two. Highest level of exposure at 46% was for TV spots. TV drama series followed at 35%. The 10% exposure to the music video was considerably lower. Results were consistent with amounts spent on the three products. Considerable differences among districts were found, with highest exposure to drama and TV spots in Jafferabad and lowest in Sukkur (see figure 1).



Among BCC activities, the drama series prompted the highest levels of interpersonal communication. A third of respondents who had seen the drama discussed it with someone and a quarter reported someone else had discussed the dramas with them. More than 70% reported the dramas and TV spots would motivate people to take action. About 23% reported intention to take action and 18% reported having already taken action due to exposure to the drama and TV spots, respectively. Actions included advising others to take care of mothers and children, seek healthcare for themselves, and practice birth spacing (see figure 2).



To examine BCC effectiveness, specific knowledge-, attitude-, and behavior-related indicators compared exposed CMWRA with those not exposed. Exposed CMWRA were significantly more likely to report the importance of skilled antenatal care and their approval of women seeking skilled antenatal care. Exposed CMWRA were significantly more likely to approve immediate postpartum care and postpartum care within the first week of birth. They were also significantly more likely to report that they and their family members approve of women receiving skilled postpartum care. The findings also showed overwhelming preference by CMWRA for the drama series "Paiman" over similar productions (see figure 3).

The qualitative PAIMAN research component reported on reactions of men and women to various communication programs and initiatives. Below are illustrative quotes from those exposed to the Paiman TV drama series. Each reflects reactions to MNH issues.

Advising others to take care of mothers and newborns

"I have told my sister that in this drama, it was told that

during pregnancy, you should take care of yourself and visit the hospital for check-ups and take good diet and adequate rest." (Age 40, education 13, urban, Rawalpindi)

"I advised my pregnant cousin to go for monthly checkups and to take care of her diet." (Age 43, education 10, urban, Rawalpindi)

"I told my pregnant sister-in-law who lives in the village to go for regular checkups and deliver at a hospital." (Age 35, education 12, rural, Rawalpindi)

"When Aab-e-Hayat was telecasted, the baby wasn't born. Now I am breastfeeding the baby myself." (Age 33, education 12, rural, Rawalpindi)

Advising men in their networks to take care of their wives

"I have advised my brother-in-law to take care of his wife after delivery." (Age 35, education 14, urban, Rawalpindi)

Visiting health facility for check-ups or plans to do so

"Whenever I am pregnant, I will go for regular check-ups and my husband will take good care of me." (Age 36, education 5, rural, Jafferabad)

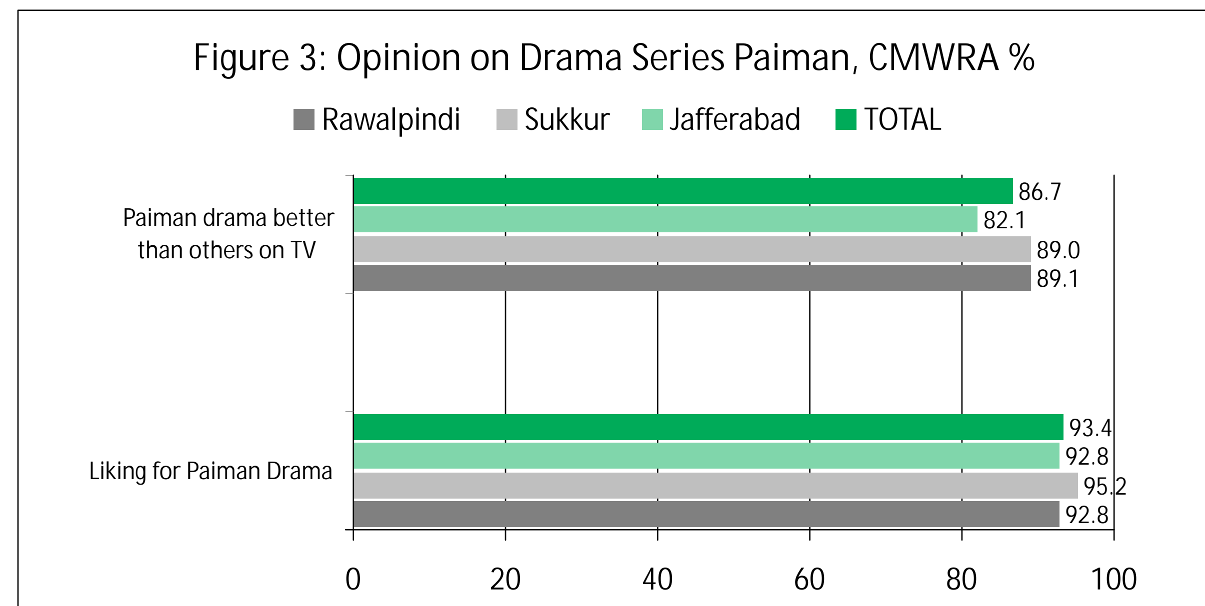


Figure 3: Opinion on Drama Series Paiman, CMWRA %

"Even before watching these dramas we used to arrange things, but we have learned new things after watching these dramas. I have decided that whether I am in pain or not, I will go for checkups and will opt for birth spacing and will arrange money for delivery in advance." (Age 28, education none, urban, Jafferabad)

Birth spacing

"My child is small I will give space in pregnancy and take care of my health and in future before delivery I will pre-arrange for vehicle, money and skilled birth attendant (Age 20, education none, rural, Rawalpindi)

TV as an education medium

Besides other findings, the study highlighted that television, whenever available, is an effective communication medium. The high rate of message recall of all three products and viewers intention to act reflected that not only did people clearly understand the contents of each product, but were also motivated to immediately take action or contemplated future action. This learning is in accordance with global evidence that has proven TV as a key medium for informing, educating, and influencing audiences.

International Learning

Literature supports strengthening family- and community-based care for postpartum period and neonatal care where health systems are weak. Darmstadt, et al. (2005) suggest that family- and community-based care, including BCC and community mobilization, stimulate adoption of improved antenatal, intra-partum, and postnatal care practices; care seeking for illness; and, in some settings, management of illness such as pneumonia by community health workers. Such care can address, in the interim, healthcare gaps and lay the foundation for improved care seeking and demand for clinical care.

Bhutta, et al. (2008) reviewed cluster-randomized controlled trials assessing effects of training community health workers. A common thread was community engagement and participation and, typically, a link with the local health system. The studies provided strong evidence of reductions in neonatal mortality, perinatal mortality, and maternal morbidity.

The World Bank ranked integrated management of neonatal and childhood illnesses (IMNCI), a strategy to provide holistic care for neonates and children, among the ten most cost effective health interventions in low- and mid-level income countries. Widely implemented worldwide, its three components are to improve health worker skills, health systems, and family/community practices. Family/community practices for child health include appropriate and timely care-seeking behavior, appropriate feeding practices, appropriate home case management, adherence to treatment plans, and community involvement in health service planning and monitoring.

Communication Challenges

In Pakistan, strategic communication for MNCH faces many challenges:

- ? Pregnancy and birth are typically seen as the female domain, and men traditionally do not become involved in pregnancy or birth decisions. However, women's low status precludes their ability to make healthcare decisions independently. Household decisions, especially those involving financial resources, are made by men, and birth preparedness (BP) often requires financial and other resources.
- ? Awareness of need for BP among women, family, and providers is low. Pregnancy is seen as a normal occurrence requiring no special preparation.
- ? Routine postpartum care is virtually nonexistent in Pakistan. Its importance in securing mother and newborn health as well as introducing FP is lacked.
- ? Widespread perception of illness being caused by supernatural, rather than biomedical, agents persists.
- ? Awareness of danger signs during pregnancy and the neonatal period is low.
- ? Intermediate steps to behavior change, such as awareness, attitudes, beliefs, and efficacy, must be addressed to facilitate eventual adoption of practices and behaviors leading to improved health outcomes.
- ? Although mass media are important BCC channels, exposure in some rural areas is low. For example, following an FP mass media campaign, 87% of Balochistan women reported not seeing or hearing an FP message in the media compared with 49% of Punjab women.
- ? Despite recent MNH attention, political commitment is yet to be translated into action. Advocacy efforts need better coordination and intensity.
- ? Designing effective campaigns requires certain capacities at district and lower levels. Lack of these capacities is a key hurdle to effective messaging.

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Program Challenges

PAIMAN works at national, provincial, and district levels to strengthen public and private HCP capacity and to improve health system infrastructure. The CAM strategy is to promote use of these skilled HCP and improve care-seeking behaviors. However, the Thematic Group on Communication recognizes the vast distance between desired behaviors and the current situation in many PAIMAN districts.

Considerations in designing the CAM strategy are:

(1) Challenging district profiles. Many PAIMAN districts are among Pakistan's most conservative and geographically-isolated, with, generally, limited mass media access. Their local government systems are undeveloped and significant security issues may exist. In these district settings, women are especially difficult to reach.

(2) Availability of MNH facilities. A PAIMAN priority to increase availability of 24/7 EmONC facilities in Project districts require significant time and effort. Not all districts have these services in place. Also, PAIMAN is improving only a limited number of facilities in each district. Creating or increasing demand for non-existent services can be counterproductive.

(3) Multiple identities for community link with formal health system. A PAIMAN interim strategy is to build capacity of the highest possible level of community worker available in the district, whether LHW, TBA, or nongovernment organization (NGO) staff. With significant gaps in LHW coverage in some districts, PAIMAN works with NGOs to provide coverage at this level in non-LHW communities. The role of linking communities with the formal healthcare system may be served by various cadres of workers, making it more difficult to promote this linkage through Project-level communication.

(4) Availability of trained LHWs. Formative research conducted very early in the Project found many communities believe the LHW has nothing to offer us. PAIMAN is providing about 30,000 LHWs with IMNCI training and interpersonal communication (IPC) and support group methodologies. All take time. Also, depending on varying district profiles, gaps in availability of trained LHWs will have CAM program implications.

(5) Varying stages of behavior change. Formative research during PAIMAN's first five years indicated vast differences in knowledge, attitudes, beliefs, and practices at provincial and district levels. Differences between the existing 10 and new 14 districts of the expanded Project are expected by virtue of the former's exposure to intensive Project interventions during the past four years. Data suggest intermediate steps of knowledge, attitudes, beliefs, and efficacy also must be addressed in order to effect behavior change.

Program Challenges

Several key factors influence PAIMAN's strategic design of CAM. First, Pakistan remains a predominantly (64%) rural society, with more than 65% of deliveries occurring in the home and a majority of households without adequate access to formal healthcare. Second, strong global evidence supports use of home-based interventions, such as exclusive BF, proper newborn care, and increased fluids for diarrhea to reduce neonatal and under-5 mortality, in low-resource settings. Third, strong evidence for the role of communication to change such behaviors exists. Geographic and cultural diversity of PAIMAN districts is vast, including varying degrees of media access. With more than 60% of the population reporting TV access, there is cost-effective opportunity to deliver consistent and effective MNCH messages through this medium. In conjunction with prevailing MNCH research, these considerations suggest the CAM strategy adopt a strategic combination of home-based, community-driven, and service-oriented interventions to achieve overall behavioral objectives.

To effectively deliver MNCH messages at the right time to the right audiences through the appropriate media, the CAM strategy orchestrates a synchronous multi-pronged approach. The overarching areas can be divided into communication, advocacy, and mobilization (CAM). More specifically, there are six strategic pathways for the expansion period.

CAM Strategic Pathways

(1) Mass Media. Strategic use of electronic and print media (TV drama serials, music videos, TV spots, TV magazine shows, print and electronic journalism).

(2) Interpersonal Communication. Reinforcement of messages, behaviors, and role modeling through personal interactions (via community mobilization, LHWs, support groups, and MNCH provider-patient interactions).

(3) Advocacy. Ongoing advocacy and networking among parliamentarians and political leaders to influence decision-making, funds allocation, and commitment to MNCH.

(4) Local Media. Strategic use of local media, including entertainment education (puppetry, local events, and fairs) and MNCH stories in local papers and media outlets.

(5) Religious Leader Orientation. Tapping into the vast network of religious leaders (*ulama*) to deliver positive MNCH messages to men in PAIMAN districts.

(6) School-based Interventions. In the extension period, CAM aims to reach teachers and students through selected MNCH messages and teachings in PAIMAN districts.

CAM intervention areas are illustrated below in a concentric circle model. Each circle represents a sphere of influence from the individual to the collective in terms of attitudes, behaviors, and beliefs.

CAM strategy will promote a package of core MNCH and FP behaviors revolving around the following behaviors:

- ? Birth preparedness (BP)
- ? Recognition of danger signs during pregnancy, delivery, and postpartum period
- ? Exclusive BF
- ? Home-based neonatal care
- ? Recognition of acute respiratory infection (ARI) danger signs in infants and children under 5
- ? Use of oral rehydration salts (ORS) for diarrhea
- ? Expanded contraceptive choice and introduction of healthy timing and spacing of pregnancy (HTSP)

A number of cross-cutting themes must be addressed to support these core behaviors. A key CAM strategy element is to position pregnancy as a special period in the life of a woman and increase the sense of responsibility for MNCH and FP among husbands, family members, and the community. The main message is *a healthy mother means a healthy family.*

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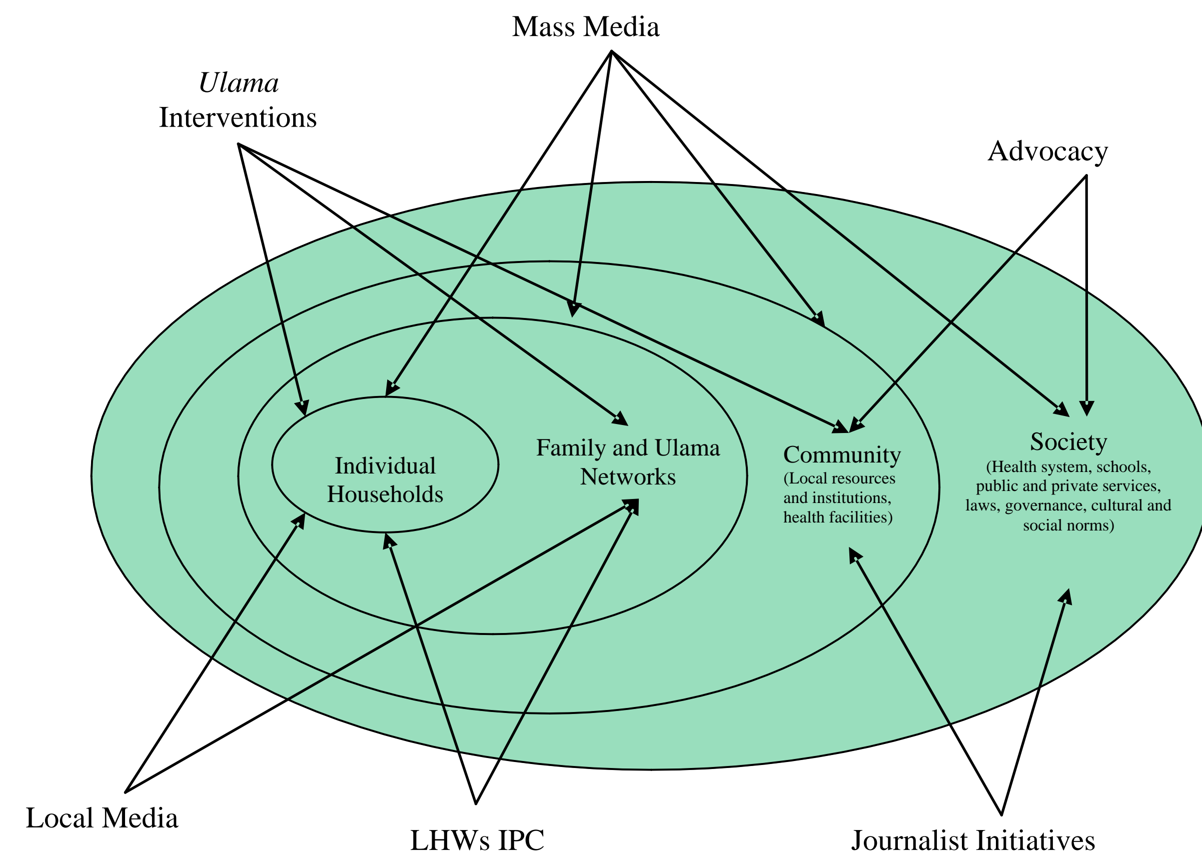
The six CAM strategy pathways will occur at three levels:

1. National and provincial. PAIMAN will improve advocacy efforts to create a more favorable environment. To increase MNCH and FP awareness, mass media activities will be conducted for the general public.

2. District. PAIMAN will build capacity in strategic communication of government and NGO partners. Using baseline research results, districts will develop specific communication action plans.

3. Community. Mobilization activities will encourage communities to take necessary actions to save mothers, newborns, and children. PAIMAN will work with implementing partners to ensure BCC consistency.

CAM community-based strategy reflects numerous



district differences in terms of behavioral change readiness, availability of services and community-based workers, and media access. Through district action plans, PAIMAN will select appropriate communication channels that are available. More emphasis will be given to advocacy and community mobilization for districts with low media access. In highly-conservative areas, greater effort will be made to engage key audiences—community leaders, elders, and ulama.

Mass media products are being developed to address underlying attitudinal barriers to behavior change and to promote specific behaviors such as BF, BP, and male support of MNCH. PAIMAN will produce a feature film on FP issues, promoting HTSP as a pivotal behavior in protecting mother and child health. Commercial film will serve as a new medium of entertainment education approach in the project, which has already proven effective with the popularity of TV drama series, Paiman. In districts with limited or no media access, PAIMAN will institute road shows that utilize mobile vans to show Paiman and other media products in addition to continuing puppetry and tapping into ulama networks.

Each communication approach will be synchronized to provide complementary, reinforcing messages.

Recommendations for Phasing

- ? Sensitize families to MNCH so they consider pregnancy a time requiring special care and attention.
- ? Increase sense of MNCH responsibility among husbands, family members, and community.
- ? Position access to health services as a basic right of women and children.
- ? Promote specific home-based care practices, such as diarrhea treatment, BF, and neonatal care.
- ? Create branding identifying LHW as a basic information source and formal health system linkage.
- ? Build upon current support for antenatal care to extend its benefits through delivery and postpartum period.
- ? Promote SBAs and EmONC facilities wherever possible.
- ? Support child immunization campaigns.
- ? Supplement efforts for repositioning FP as a

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health and lifesaving intervention.

Sustainability through Partnerships

Strategic PAIMAN communication will select key partnerships to replicate interventions, thereby maximizing benefits with available resources. Instead of bringing new trainers for LHWs, PAIMAN will conduct training of trainers (ToT) of existing trainers so trickle down of new standards continues even after Project-end. Similarly, PAIMAN will work with district education departments rather than individual teachers.

Theoretical Base

As theoretical underpinning, the CAM strategy employs an ecological approach that assumes health is shaped by many environmental sub-systems, including family, community, workplace, cultural beliefs and traditions, economics, physical world, and web of social relationships. A combination of BCC theories applied include, but not limited to, Steps to Behavior Change (Piotrow, et al. 1997), Social Learning Theory (Bandura), and Diffusion of Innovation and Ideational Theory (Kinkaid). A number of cross-cutting issues affect health outcomes, including poverty, education, and women's status. While PAIMAN is unable to address all underlying issues, a thorough understanding and appreciation of these conditions are necessary for effective program design. Using a social ecological framework to understand the complex interplay among individual relationships, community, and societal factors will provide the context for behavior change at community and household levels.

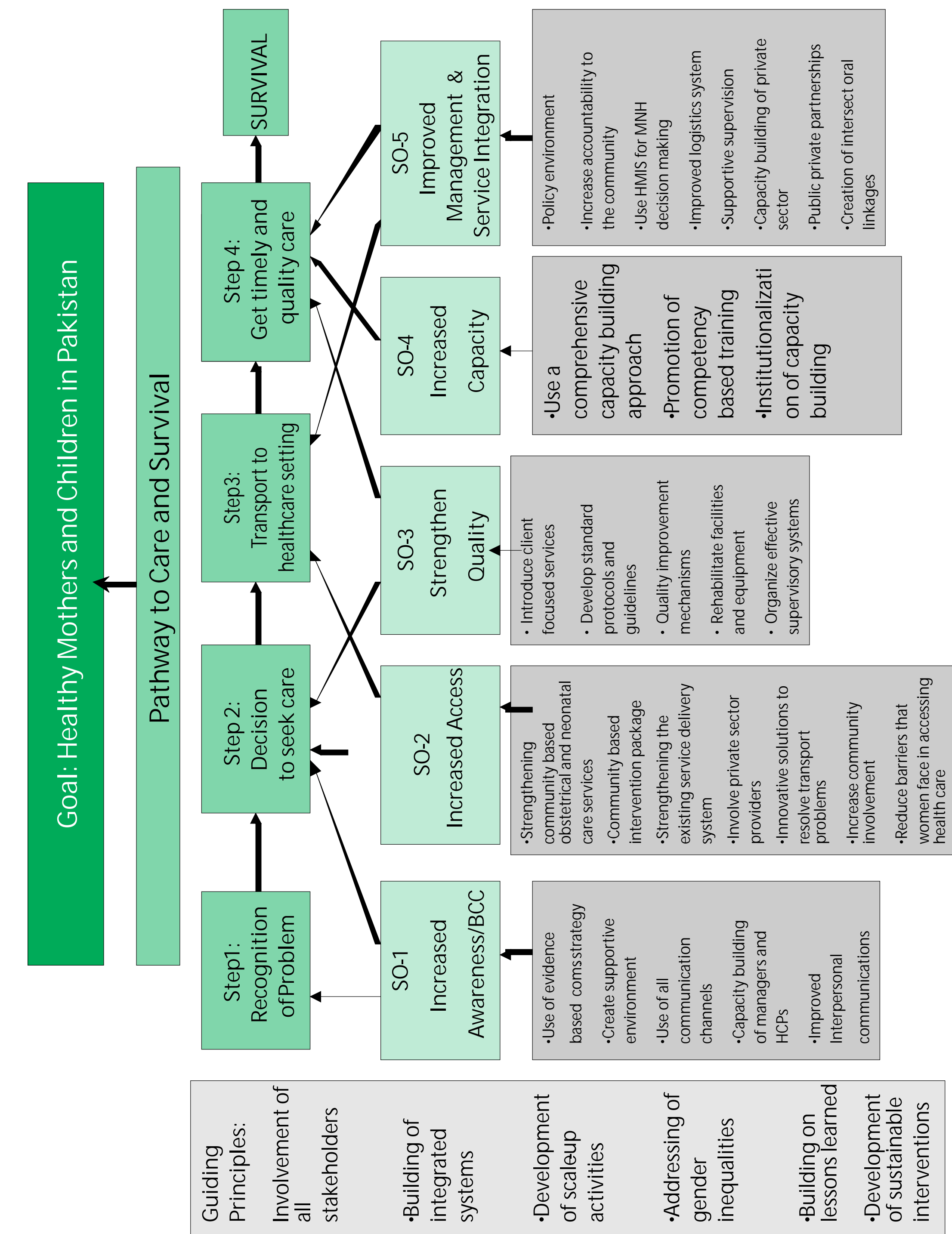
Strategic Framework

The strategic framework on which PAIMAN is based, *The Pathway to Care and Survival*, follows a series of steps necessary to improve survival of mother and newborn in event of complication or illness.

The framework is based on *the three delays* identified by Thaddeus and Maine that explain high mortality caused by obstetric emergencies. The three delays are: 1) Delay in recognizing there is a problem and deciding to seek care, 2) Delay in transporting the woman to a facility that can provide that care, and 3) Delay in receiving treatment at the facility.

The framework below presents these delays in four steps. The next level depicted in the framework presents how PAIMAN's five strategic objectives relate to each step in the Pathway to Care and Survival. BCC is particularly relevant for the first three steps: recognizing danger signs, deciding to seek care, and arranging for transport in advance of an emergency. These steps constitute BP at household and community levels. In a number of countries, CCP implemented highly-effective campaigns to promote how communication impacts BP.

The Steps to Behavior Change (Piotrow, et al. 1997) further illuminate the process followed in behavior change, progressing from changes in knowledge, attitudes, and beliefs to intention and action, practicing the behavior, and advocacy. Understanding the steps to behavior change allows planners to determine the kinds of messages needed to move people to adopt positive behaviors. In many PAIMAN districts, these messages must begin with the initial stage of increasing knowledge and awareness.



Roles and Responsibilities

PAIMAN communication refers to activities that change individual behavior, advocacy refers to activities seeking societal and political change, and mobilization refers to activities that motivate communities to act in a concerted fashion. JSI and CCP implement the advocacy component at national and provincial levels. CCP manages the communication component, consisting of mass media products and innovative community-level interventions such as involving *ulama* and puppetry to effect individual behavior change and create new societal norms. Community mobilization partner SC/US is responsible for implementing community mobilization activities in all PAIMAN districts.

CAM Strategy

Following is a description of CAM-intended audiences with objectives and sub-objectives, activities, and monitoring and evaluation indicators. See Table 1 for Phases 1 and 2 messages for each audience group.

Audience 1: Women of Reproductive Age

While women remain a primary PAIMAN audience, they are, by nature of social context, unfortunately secondary in making decisions regarding care seeking during obstetric emergencies. Husbands and family members, HCP, and community members must contribute to the decision-making. Globally, this paradigm shift is described as shared responsibility to ensure safe delivery and a healthy baby and acknowledges women are vulnerable during and after delivery. Women's decisions regarding HTSP and FP are often secondary to husbands' and family members', especially mothers-in-laws'. Women's low status does not carry the same negative impact on children's health. Women are able to take steps at the household level to ensure their children's well-being, growth, and development. They are more likely to employ more independence in determining when and where to seek care for sick children.

Objectives

1) To empower women to take necessary steps during pregnancy, delivery, and postpartum periods to ensure they and their newborns experience safe and healthy delivery.
2) To facilitate the growth and development of the newborn over the next five years.
3) To ensure their next child is planned and wanted.

Sub-objectives

Pregnancy and Birth Preparedness

- ? To increase the number of pregnant women who consider pregnancy a special condition requiring good food, rest, and preparedness.

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- ? To increase the number of women aware that complicated pregnancy and delivery can endanger their and their baby's lives.
- ? To increase the number of women with a BP plan.
- ? To increase the number of pregnant women who know danger signs during pregnancy / delivery/postpartum period.
- ? To increase the number of pregnant women aware of how and where to access appropriate care.

Neonatal Care

- ? To increase the number of pregnant women who know the importance of 1) Early wrapping of the baby, 2) BF soon after birth, and 3) Delayed bathing.
- ? To increase the number of mothers who know danger signs in neonates and actions required.

Family Planning

- ? To increase the number of women who know benefits of birth spacing and how and where to access contraceptives.

Child Health

- ? To increase the number of women who practice exclusive BF for up to six months, who introduce semi-solids at around six months, and who continue BF for up to 2 years.
- ? To increase the number of women who practice diarrhea treatment protocol for sick children, correctly prepare and administer ORS, continue to BF and give other foods, and consult a HCP for severe cases.
- ? To increase the number of women who know the danger signs of acute respiratory infection (ARI) in a child and appropriate actions.
- ? To increase the number of women who complete the full schedule of immunizations for their children according to Expanded Program on Immunization (EPI) guidelines.
- ? To increase the number of women who provide a stimulating environment for the child, one that promotes learning and development.

Activities

Home visits by LHWs: The MOH appointed 110,000 LHWs to provide health education and preventive care to rural communities. The approximately 11,000 in 23 PAIMAN districts will be given refresher training and support to conduct household visits with BP, postpartum care, neonatal and child health, and birth spacing messages. In some areas, LHW visits are extremely important for some women, they might be the only PAIMAN contact by a health educator.

Women support groups: Mobilizing women at the community level will help disseminate key MNCH and FP messages. Where available, LHWs will facilitate these support groups. In other areas, PAIMAN Grantee NGOs will facilitate these meetings. SC/US Community Mobilization Officers (CMOs) will work closely with LHWs to facilitate meetings and empower women to make healthier choices for themselves and their newborns. Existing information, education, and communication (IEC) materials on BP, postpartum and neonatal periods, child health, and birth spacing prepared by Saving Newborn Lives Initiative will be reproduced for LHWs to use for household visits and women support groups. Additional IEC materials will be developed to cover new topics and accommodate feedback from the field.

Mass media support: At national and provincial levels, mass media will be used to reinforce messages for all audiences. An umbrella concept capturing actions needed to avoid the three delays will be developed. The PAIMAN strategic framework, Pathway to Care and Survival, recognizes that several elements must be in place for women to survive obstetric emergencies. Radio and TV spots will be developed and broadcasted for various audiences. A 13-episode TV drama series will be produced each discussing a distinct issue highlighted by PAIMAN formative research that affects MNCH in Pakistan. In order to highlight the importance of family planning and for generating discussion on the issues in media and among policy circles, a high quality feature film utilizing the most creative talent of Pakistan will be produced and widely distributed both through cinema houses and TV channels.

Video on Wheels/Road Shows: PAIMAN is working in some of the remotest districts of Pakistan. Mass media reaches to only around of the population in these districts. PAIMAN will use mobile vans to take its media products, i.e. the drama series, music video and TVCs, to those who do not have access to TV. Mobile shows will be organized in remote areas of the project districts providing the much needed entertainment to

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local people who will be informed through local NGOs, community representatives and PAIMAN community mobilization partners a day before of the planned shows.

Putlee tamasha: This traditional, inexpensive, and easy-to-stage form of puppetry is extremely popular with men and women in rural areas. Local puppeteers will be trained to convey BP, optimal child care practices, and birth spacing messages. They will be supported to stage *putlee tamashas* in far-flung areas.

School assemblies: In Pakistani society, teachers command special respect, especially in rural areas with low literacy rates. Community members consult teachers on a wide variety of issues, as they are considered knowledgeable about the modern world. PAIMAN will work with the education department to solicit support of local female teachers and schools in creating awareness about MNCH issues. In local schools, special MNCH activities such as women's assemblies, celebrations of important days, video screenings, and *putlee tamashas*, will be held.

NGO fairs. PAIMAN will encourage local NGOs to organize special MNCH fairs at union council and village levels. Fairs will enhance awareness about MNCH and gain support for PAIMAN activities. PAIMAN stalls will be available at community gatherings and local fairs where IEC materials (posters, hand bills, cassettes), and small items such as key chains, bags, money saving boxes, and wallets will be distributed.

Monitoring and Evaluation Indicators

- ? Number of support groups
- ? Number of media campaigns
- ? Number of LHW discussing BP messages with women
- ? Number of women with BP plan
- ? Number of women who intend to deliver with SBA
- ? Number of women who deliver with SBA
- ? Number of women who initiate BF within first hour
- ? Number of women who continue exclusive BF for 6 months
- ? Number of women who initiate semi-solid foods at 6 months, in addition to BF
- ? Number of women who know how to prepare and administer ORS
- ? Number of women who know the danger signs in a child suffering from ARI
- ? Number of children fully immunized per the EPI schedule

Audience 2: Husbands and Other Family Members

Husbands and other family members, particularly mothers-in-law, strongly influence household care-seeking behaviors. They are critical in determining whether a pregnant woman will receive necessary care. Messages that motivate family members to assume greater responsibility for women's safety and wellbeing in pregnancy, delivery, and postpartum periods are keys to improving maternal health outcomes.

Objectives

1) To motivate husbands and family members to assume responsibility for the pregnant woman throughout pregnancy, delivery, and postpartum periods to ensure safe outcomes for mother and newborn.

2) To ensure physical and emotional health of the child during child's first 5 years of life.

3) To ensure the next child is planned and wanted.

Sub-objectives

- ? To increase the number of husbands and family members who recognize pregnancy as a special condition requiring preparation, nutritious food, and rest.
- ? To increase the number of families with a BP plan.
- ? To increase the number of husbands and family members who know the danger signs during pregnancy, delivery, and postpartum period and are aware a complicated delivery can endanger mother's and baby's lives.
- ? To increase the number of husbands and family members who accept responsibility for their child's health and know the importance of 1) early wrapping of newborn, 2) initiating BF within the first hour of birth, 3) delayed bathing of newborn, 4) exclusive BF for six months, 5) initiating semi-solid foods at six months, 6) continuing BF for two years, and 7) completing immunizations according to EPI schedule.
- ? To increase the number of husbands and family members who know the danger signs for neonates and appropriate actions

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required.
- To increase the number of husbands and family members who know the danger signs for diarrhea and ARI in children under age 5 and actions required.
- To increase the number of husbands and family members who approve of using contraceptives to space births.

Activities

Male health sessions: Under the Women's Health Project, LHWs were to organize male support groups. This arrangement in most cases did not work due to cultural constraints of women talking to men about reproductive health issues. PAIMAN will contact men though a special mechanism of offering grants to selected NGOs in each districts. These NGOs will work with local communities on various MNCH issues and also organize male group meetings. Similarly SC/US-, the main PAIMAN consortium partner entrusted with community mobilization activities in all districts in the extended project phase, will identify and train male volunteers in various communities in organizing male health sessions. Each volunteer will organize two male health sessions per month. The performance of these volunteers will be monitored by the community mobilization staff of SC/US. Local LHWs will also report the activities of these volunteers along with those of their own.

LHWs/TBAs: Where possible and culturally appropriate, LHWs and TBAs will support male support group activities. Both groups of women have special community standing. Husbands, in particular, look to TBAs when complications arise and decisions must be made about referral to a health facility. In certain districts, it will be possible for TBAs to join support groups at certain points and educate them about the three delays and other MNCH issues.

Multimedia support and NGO fairs: These activities will be similar to those organized for women.

Monitoring and Evaluation Indicators

- Number of active male support groups
- Number of LHWs/TBAs delivering BP messages to husbands and family members
- Number of people reached by media activities
- Number of NGOs promoting BP for MNH
- Number of *Hujra/Chopaal* meetings held
- Number of families who know benefits of using CDKs
- Number of husbands and family members who intend to engage an SBA
- Number of husbands and family members who know pregnancy / delivery danger signs
- Number of husbands and family members who know danger signs in a neonate
- Number of husbands and family members who ensure initiation of BF within first hour
- Number of husbands and family members who ensure mother continues exclusive BF for 6 months
- Number of husbands and family members who ensure initiation of semi-sold foods at 6 months
- Number of husbands and family members who know how to prepare and administer ORS
- Number of husbands and family members who know the danger signs in a child suffering from ARI
- Number of children fully immunized according to EPI schedule

Audience 3: Community Leaders

As role models, community leaders in PAIMAN areas, including NGO and community-based organization (CBO) staff, teachers, village elders, elected representatives and other locally-designated leaders, can be vital to improving MNCH behaviors and practices. PAIMAN aims to identify and build lasting relationships with strong local leaders and empower them with information, skills and resources needed to support MNCH. These catalysts to improved MNCH outcomes will be engaged through various activities and at multiple levels. CMOs are responsible for coordinating this component, but implementation will be a major undertaking by the entire team.

Objective

To motivate community leaders to take responsibility for improvement of MNCH facilities in their area and building their village, union council or district into a MNCH model.

Sub-objectives

- To increase the number of community leaders who actively support the process of upgrading local MNCH services in their areas.
- To increase the number of community leaders who initiate MNCH activities to improve MNCH outcomes in their communities.

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- ? To increase the number of community leaders who support BP initiatives, including community-saving schemes, blood donations, and community transportation arrangements.
- ? To increase the number of community leaders who support community initiatives for child health, including nutrition, immunization, and appropriate treatment for common childhood illnesses.

Activities

Community Mobilization: PAIMAN will initiate a capacity-building process through which community individuals, groups, and organizations plan and implement activities to improve MNCH outcomes in their communities. This process will begin with a community mapping exercise, with communities identifying key issues and priorities in their areas. Community mapping will include key informant interviews, stakeholder meetings, large community meetings, and focus groups with participatory exercises. Local leaders will be identified and brought on board as role models and participants in local MNCH programs.

Each district will develop a Communication Action Plan that takes into account available resources, population size, immediate needs, and experiences of each community. There will be common linkages across each district and community, such as formation of community-based health committees (HCs) and men's and women's support groups. With community partners, PAIMAN will develop and initiate community-led advocacy for MNCH efforts. Community mobilization activities are described below.

Facility-based HCs: HCs will be formed at each health facility selected for improvement/upgrades. HCs will be comprised of local notables, elected representatives, and community and religious leaders. Members will determine their HC's organizational structure and functions. HCs will serve as primary forum for MNCH learning, mobilization, and action within each community. HCs will be responsible for guiding the health facility improvement process and involving community members and organizations when needed. Examples of mobilization activities include generating emergency transport systems, creating emergency MNCH funds, partnering with organizations for referral and transport, and conducting outreach sessions for pregnant women and their husbands. HCs will be the primary catalyst for MNCH initiatives in their communities. Other groups will be formed as needed.

Community meetings: Community meetings will be important throughout the mobilization process. Small, focused meetings as well as larger, awareness-raising meetings will be held at various junctures. In the community mapping process, community members will meet with local religious leaders, health officials, and other community members to determine key MNCH priorities for their area. HC meetings will provide an ongoing forum for decision making and garnering support for health facility improvements and initiation of community-based activities.

Briefing of local assemblies/councilors: Community leaders will be orientated on how to advocate with local assembly members to improve MNCH services. Training will enable community leaders to conduct effective briefings and meetings with local assemblies and councilors on MNCH issues. PAIMAN will develop advocacy and briefing materials to facilitate meetings.

District-level TV talk shows: Talk shows will feature local *Nazims*, Executive District Officers (EDOs), District Coordination Officers (DCOs), and District *Khateebs* (District head priest cleric). Shows will overview Pakistan's MNCH situation, including district MNCH indicators (where available) and description of MNCH facilities in each district. They will feature interviews with community members, service providers, and locally-elected officials. Prospective shooting locations are district halls, which would allow general public participation. Purposes will be to garner support for MNCH activities within each district, increase local and national accountability, and increase demand for improved services and practices. Shows will benefit local community leaders and others by: 1) Establishing a video record of the situation at baseline, 2) Creating awareness about each district's state of affairs, and, 3) Highlighting PAIMAN's program to improve MNCH in health facilities.

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Mass media support. Although not a specific part of the mass media program, community leaders may be featured in TV drama's as role models for MNCH change. Because the district TV drama may be aired nationally, modeling of a positive community leadership role may motivate involvement of local and national stakeholders as well as wider public audiences.

Monitoring and Evaluation Indicators

- ? Number of facility-based HC meetings
- ? Number of specific actions taken by HCs to improve MNCH in their areas
- ? Number of briefing sessions for local assemblies/councilors
- ? Number of TV talk shows
- ? Number of community leaders identified who actively support community BP initiatives
- ? Number of community-based MNCH activities initiated

Audience 4: *Ulama* (Religious Leaders)

Ulama are important in the daily lives of most Pakistanis. Many seek *ulama* for guidance on various issues, including health and wellbeing. In hard-to-reach areas, *ulama* are sometimes the only medium of communication. Thus far, little attention has been paid to involving *ulama* in MNCH communication efforts. PAIMAN will focus on sensitizing *ulama* leadership regarding need to highlight MNCH issues, especially women's rights to healthcare during pregnancy/delivery/postpartum period and importance of BP.

Objective

To sensitize religious leaders to advocate MNCH issues at district and community levels.

Sub-objectives

- ? To increase the number of *ulama* who discuss importance of women's rights in Islam, including their right to healthcare during pregnancy, delivery and postpartum period.
- ? To increase the number of *ulama* who discuss the importance of children's rights in Islam, including their right to healthcare.
- ? To increase the number of *ulama* who support FP as a health and lifesaving intervention.

Activities

Sensitization training sessions: An NGO experienced in working with *ulama* for PAIMAN will be sub-contracted to help orientate *ulama* on current MNCH issues. Sensitization trainings will be imparted at provincial and district levels so provincial differences can be aptly addressed. Trainings will sensitize *ulama* and seek their support for program activities. PAIMAN will provide *ulama* with materials that can be integrated into their existing educational activities.

Advocacy booklet for *ulama*: CCP advocacy booklet for *ulama* prepared in PAIMAN's first phase will be revised to include gaps identified in previous versions. The booklet contains chapters on Islamic teachings in light of the *Holy Quran* and MNCH sayings of the Prophet Muhammad (peace be upon him). It also contains a set of messages on maternal health during pregnancy, at the time of and after delivery, with emphasis of newborn care and home-based remedies such as exclusive BF and vaccination of children under the age of 5 years. This revised booklet will feature testimonials of the most senior leaders of various schools of *ulama* thought and will be distributed to *ulama* by the sub-contracted NGO.

Appointment of special *ulama* spokesperson: PAIMAN will continue supporting a spokesperson for the *ulama* who champions MNCH issues. Similar to a goodwill ambassador, the *ulama* spokesperson is a respected leader able to influence peers and available to represent the MNCH perspective at different venues as needed.

Creation and support of *ulama* networks: PAIMAN will continue work with the sub-contracted NGO to establish *ulama* networks that can be engaged to encourage appropriate birth preparedness and complication readiness behaviors. PAIMAN will develop a quarterly newsletter for *ulama*, with talking points and educational information to share with followers. Special awards will also be conferred to those *ulama* who have been actively participating in PAIMAN activities.

Monitoring and Evaluation Indicators

- ? Number of briefing/training sessions
- ? Number of *ulama* spokes persons appointed
- ? Number of networks established

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- ? Number of *ulama* giving MNCH messages during sermons at Friday prayers

Audience 5: Traditional Birth Attendants

Increasing use of SBAs continues to be a major PAIMAN emphasis. Currently, two of three women in Pakistan deliver in their homes under TBA care. Evidence suggests TBAs can play an important role during the transition to facility-based care and that some aspects of home-based care can achieve significant improvements in health outcomes. In its first phase, PAIMAN trained TBAs in clean delivery practices and care of the newborn, recognition of early warning signs, and timely referral to professional care. Refreshers will be conducted in the second phase.

Objective

To improve TBAs' ability to play an appropriate role during delivery and postpartum period through use of CDKs, increased knowledge of danger signs for mothers and newborns, and timely referrals to a facility and/or skilled medical personnel.

Sub-objectives

- ? To increase the number of TBAs who use CDKs.
- ? To increase the number of TBAs who know the danger signs of obstetric complications and where to refer emergencies.
- ? To increase the number of TBAs who know the danger signs for neonates and actions to be taken in consideration of their appearance.
- ? To increase the number of MNH referrals by TBAs.

Activities

Selected TBAs in project district will be provided orientation on clean delivery practices. The orientation sessions well reinforce good hygienic practice, particularly during labor and delivery; identify early signs of complications during labor; and make timely referrals to a health facility. TBAs will also be provided with a simple, illustrated brochure to help them remember main points.

Mass media support. When possible, PAIMAN will employ mass media to reinforce appropriate role of TBAs for pregnancy, delivery, and postpartum care. For example, a social drama may have a TBA character who understands the value of a trained delivery provider and aids the family with that decision. Another story may have the TBA refer a patient in a timely fashion and choose to accompany her to a facility.

Monitoring and Evaluation Indicators

- ? Number of TBAs trained
- ? Number of TBAs who use CDKs
- ? Number of TBAs who know at least four danger signs of pregnancy/ delivery and newborn complications and where to refer emergencies
- ? Number of TBAs who make timely referrals in emergencies

Audience 6: Formal Health Service Providers

LHWs and SBAs (Lady Health Visitors, Women Medical Officers, Medical Officers, General Practitioners, Gynecologists, Pediatricians, and Anesthetists) have regular contact with families. For rural populations, LHWs are the main source of health information and education and LHVs and MOs the main service providers for families. General Practitioners and Woman MOs/Gynecologists, respectively, have the same roles in urban areas. Communities are likely to go to these sources for verification of information gleaned through the media. Bringing these health service providers on board is a key PAIMAN component.

Objective

For all provider cadres: To increase the number of providers who counsel patients and families regarding importance of antenatal care, BP, use of SBAs for delivery, and proper child care, including BF and nutrition, immunizations, home-based care for illnesses, and recognition of danger signs.

For skilled providers: To increase the number of providers who offer skilled care for normal and complicated pregnancies and during the postpartum period.

Sub-objectives

- To increase the number of HCP who consider pregnancy a special time that requires special care, support and preparedness.
- To increase the number of providers who encourage clients to have a BP plan.
- ? To increase the number of HCP who educate pregnant women about CDKs and newborn care, including early wrapping and delayed bathing of newborn.
- To increase the number of HCP who educate pregnant women and family members about

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danger signs for neonates and treatment decisions.

- To increase the number of HCP who counsel pregnant women about BF and feeding practices, including initiating BF soon after the delivery and exclusive BF for up to six months.
- To increase the number of HCP who counsel pregnant women about initiating contraceptive use at six weeks postpartum.
- To increase the number of HCP who educate families on how to prepare and administer ORS.
- To increase the number of HCP who educate families about danger signs in a child suffering from ARI.
- To increase the number of HCP who advise that children be fully immunized according to the EPI schedule.

Activities

Incorporate BP and IMNCI into in-service and pre-service health service provider training courses: PAIMAN will advocate with the College of Physicians and Surgeons Pakistan, University of Health Sciences, National Program of Family Planning and Primary Health Care, Nursing Institute, and other organizations to include BP in their curriculum and train professionals on communicating with families about benefits of a BP plan.

Distance learning program: Special programs will be aired on appropriate electronic media to help health service providers understand the importance of social support for MNCH and to empower women to negotiate MMH issues with husbands and families.

Awards/incentives: Appreciation awards, including media coverage, will be bestowed upon best performing district-level health service providers.

Seminars for district/*tehsil*-level health providers: PAIMAN will offer tailored events for public and private sector health professionals in formal and informal sectors. Seminars will describe respective MNCH situation, relevant details of PAIMAN-provided services, and HCP roles and responsibilities.

Mass media support: Various media products such as TV drama serials, talk shows, and TV commercials designed for the general public will help sensitize HCP to women's needs. They will also benefit from above-described distance learning programs.

Monitoring and Evaluation Indicators

- ? Number of HCP trained
- ? Number of distance learning programs broadcast
- ? Number of appreciation awards bestowed upon HCP
- ? Number of district/*tehsil* seminars for HCP

Audience 7: Journalists

Print and electronic news media may have a limited role in creating MNCH awareness in rural Pakistan due to widespread illiteracy and limited TV and radio access. However, their value as advocacy tools cannot be over-emphasized. PAIMAN's media advocacy will not only target journalists but also media managers and editors. PAIMAN will work to increase and improve coverage on MNCH issues and women's healthcare rights.

Objective

To increase and improve news media coverage of MNCH and FP issues.

Sub-objectives

- ? To increase the number of journalists who report on MNCH issues and importance of planning family size.
- ? To improve quality of MNCH coverage.
- ? To increase the number of journalists who know a complicated delivery can endanger a baby's life.
- ? To increase the number of journalists who know the majority of infant and child deaths can be prevented through simple steps: exclusive BF, full immunization, appropriate treatment of diarrhea, and timely ARI care-seeking.

Activities

Training/Briefings: PAIMAN will train journalists extensively on how to make MNCH issues newsworthy and will provide a resource list of experts who can be interviewed.

Fact Sheets/Materials: An MNCH information packet of fact sheets and examples of media coverage in Pakistan and other countries will be developed and distributed at training courses and special media events. Fact sheets will feature stories from the field and MNCH statistics.

Networking: PAIMAN will support a network of journalists to meet bi-annually for technical updates, networking, and sharing resources.

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National MNCH Media Award: PAIMAN will initiate this to encourage journalists to write about MNCH, and FP issues and to reward committed journalists who highlight these issues in print and electronic media.

Monitoring and Evaluation Indicators

- ? Number of journalists briefed/trained
- ? Number of journalist networks established and frequency of their meetings
- ? Number of journalists awarded for coverage
- ? Number of press reports/media programs on MNCH

Audience 8: *Nazims* and Parliamentarians

Under Pakistan's present democratic system and the devolved system of local government, national and provincial Parliaments and District Councils make policy decisions, including health policies. Emphasizing the importance of MNCH to these decision makers is crucial; it will result in allocation of funds for MNCH and ensure continuity. PAIMAN will inform and sensitize policymakers to MNCH issues and steps they can take to address them.

Objective

To increase policy and decision makers' support for MNCH at all levels so they allocate resources accordingly.

Sub-objectives

- ? To increase the number of *nazims* who support women's maternal health initiatives by devoting more resources.
- ? To increase the number of parliamentarians who advocate MNCH.

Activities

Orientations/briefings/advocacy kits: PAIMAN will develop an advocacy kit that highlights costs of maternal and newborn mortality to families, communities, and the country. Included will be a 10-minute video presentation, fact sheets, and supporting materials.

Theatrical performances: PAIMAN will create a live theater piece that juxtaposes the story of a woman who survives an obstetric emergency because her family took immediate action with a story of a woman who dies due to delays in recognizing danger signs and arranging transport.

Training for government leaders: PAIMAN will provide training to increase capacity in leadership, communication, and advocacy skills. Talking points for district-, provincial- and federal-level policy/decision makers will be developed and distributed.

Advocacy for MNCH: PAIMAN will lobby for implementation and promotion of the National Breastfeeding Law. PAIMAN also will develop new ideas for national celebration of Mother's Day.

Special awards: *Nazims* and parliamentarians who achieve goals outlined above will receive awards from PAIMAN. Awards will be presented by important Pakistan personalities on special occasions, such as Mother's Day.

District-level TV talk shows: Talk shows will feature local *nazims*, EDOs, DCOs, and District *Khateebs* (district head clerics). Details were discussed earlier.

Mass media support: Using mass media, PAIMAN may identify supportive parliamentarians/*nazims* as role models. Other PAIMAN media products such as drama serials and TV commercials will also indirectly impact public representatives.

Monitoring and Evaluation Indicators

- ? Number of briefing kits produced and distributed
- ? Notification of the establishment of House Committee
- ? Number of theatrical performances
- ? Number of press reports on Mother's Day
- ? Number of awards
- ? Number of provincial and district Safe Motherhood Alliances established
- ? Number of TV talk shows aired
- ? Production of a documentary
- ? Inclusion in annual national and district budgets

Audience 9: District, Provincial, and Federal Bureaucrats

Planners and policy-makers strongly influence decisions at all levels. PAIMAN will inform and build capacity of federal-, provincial-, and district-level bureaucrats in understanding MNCH and responding with favorable policies.

> *"Launched in 2004 for a period of five years and focused on maternal and newborn health in ten districts, PAIMAN received in 2008, a one-year extension, through September 2010."*

Objective

To motivate policymakers to foster an environment that supports survival of pregnant women, newborns, and children.

Sub-objectives

- ? To increase the number of officials who support MNCH initiatives by devoting more resources.
- ? To increase the number of officials who advocate MNCH with fellow bureaucrats.

Activities

<u>Special briefings at National Institute of Public Administration (NIPA), Staff College, National Defense College</u>: PAIMAN will develop, for the Pakistan Administrative Staff College, National Defense College, and National Civil Services Academy, MNCH courses that explain maternal and neonatal health as a human development issue.

<u>Trainings/Orientations</u>: PAIMAN will increase the capacity of national, regional, and local leaders to help reduce maternal, neonatal, and child mortality and morbidity by building their leadership, communication, and advocacy skills. Fact sheets with talking points for district-, provincial-, and federal-level policy and decision makers will be developed and distributed.

<u>Performance Awards</u>: In appropriate forums, PAIMAN will acknowledge support of government officials for PAIMAN goals and activities.

Monitoring and Evaluation Indicators

- Number of trainings and orientations
- Number of fact sheets distributed
- Number of bureaucrats awarded
- Number of briefings held at NIPA, Staff College, and National Defense College
- Number of annual national and district budgets allocating additional resources to MNCH services

CAM Message Matrix

No.	Sub-objective	Existing Beliefs/Practices	Message Content
		WOMEN	
1	*Increase number of pregnant women who consider pregnancy a special condition that requires good food, rest, and preparedness.*	In Buner, it is considered shameful to share news of pregnancy, including with women in the household, because pregnancy is related to sex. Women report no extra food or rest during pregnancy.[7]	Pregnancy is a special time that requires extra support and attention. You will need emotional and physical support during pregnancy. Talk to your husband and family members about your concerns.
		Any number of foods is perceived as forbidden during pregnancy. Foods vary by district.[8].	Be sure to eat plenty of eggs, meat, legumes, milk, fresh fruit and vegetables. Wash hands before preparing and eating food.
2	*Increase number of women who are aware a complicated pregnancy and delivery can endanger their and their baby's lives.*	Feelings of fate and inevitability or denial about complications are the norm. Women wait to inform husbands about complications.[9]	Many women suffer health problems during pregnancy, delivery, and in hours and days following birth. With timely care, most can be easily treated by a doctor. You and your baby deserve the best health care possible.
3	*Increase number of women who have a birth preparedness plan.*	During their last pregnancy, only one-thirds of rural women discussed location of delivery with their husbands. Women are more likely to set aside funds than to discuss BP with husbands. In NWFP and Balochistan, 36%-38% discussed BP with husbands while less than half set aside funds.[10]	Even if you feel healthy or gave birth before, you still need to plan for an emergency. By planning ahead, you protect not only your health but your baby's as well. With your husband or female elders, discuss preparations for emergencies. You need to know where to go and how you will get there. Set aside funds for fees.
		Less than one-thirds (29%) of rural women employing home birth used a CDK and 82% used un-boiled thread to tie cord while 58% used a new razor blade.[11]	Use a CDK for home birth.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
4	*Increase number of pregnant women who know the danger signs during pregnancy/delivery/ postpartum period.*	Delays in deciding to take the woman to a health facility appear predominant factors in mortality in Pakistan. Danger signs during pregnancy tend not to be addressed until delivery.[12]	**Pregnancy danger signs:** - Vaginal bleeding - Swelling of face, hands - Severe headaches, blurry vision - Gush of fluid from vagina - No movement from baby - Persistent contractions at <37 weeks
		Very limited knowledge of danger signs exists. Women knew about bleeding during pregnancy; bleeding, retained placenta, and prolonged labor during delivery; and bleeding and fever during postpartum period. In Buner, 16% of women could name >3 danger signs; 23% in DG Khan and Jhelum.[13]	**Delivery danger signs:** - Labor lasting >12 hours - Placenta not flushed within 30 minutes of birth - Headaches, fits, blurry vision - Heavy bleeding - Baby's arm, leg, or cord is the presenting part - Drowsiness, pulse >100/minutes, cold skin
		Only extreme bleeding is seen as dangerous. More subtle signs (e.g., pre-eclampsia) not recognized.[14]	**Postpartum danger signs:** - Excessive heavy bleeding - High fever - Headaches, fits, blurry vision - Pain in lower abdomen - Foul-smelling vaginal discharge - Swollen or sore breasts
		Very low district rates of postpartum care for women who delivered at home (3-21%) despite a significant amount of approval for postpartum care (25-60% among women). Mother/baby confined in postpartum period because of strong beliefs in evil spirits. Mobility very limited, with strict restrictions on who can come into contact with the woman.[15]	

No.	Sub-objective	Existing Beliefs/Practices	Message Content
5	*Increase number of women who are aware of how and where to access appropriate care*	Positive attitudes toward antenatal care but low utilization due to low mobility of women and lack of access. Only 8% and 17% of women made at least 3 visits in districts Jafferabad and Buner respectively. Only 31% of women in Balochistan are immunized against tetanus.[16]	Pregnant women should see SBA four times during pregnancy, receive two immunizations against tetanus, and take iron supplements to maintain strength. If you do not know where to go for antenatal care, ask the LHW or LHV.
		Less than 77% of women in PAIMAN districts approve of using SBA for delivery. Perceptions are Government hospitals are of low quality and doctors are rude and hospital deliveries lack privacy and are humiliating.[17]	Use SBA for delivery and postpartum period, even if you have given birth before. No one knows which woman will have problems during delivery. SBA can recognize problems and make timely referrals.
6	*Increase number of pregnant women who know importance of initiating BF within one hour of birth, early wrapping of baby and delayed bathing of baby.*	Nationally, 29% of babies' breastfed within first hour.[2] This rate is 6% in Lasbela, and 10% in Jafferabad and Buner respectively.[1] Two-thirds of babies given colostrum while pre-lacteals is common. Colostrum seen as negative in DG Khan and Khanewal.[18]	Be sure to BF your new baby soon after birth. Colostrum is your baby's perfect first food. Give your baby breast milk and nothing else. Baby comes from a very warm environment, so your home feels cold to baby. Wrap and hold baby right after birth.[19]
		Vernix considered dirty.[20]	Wait 7 days before bathing baby; bathing will make baby cold. The vernix is baby's natural clothing, just like we wear clothes to protect our body, so keep it clean, God has given baby vernix for protection.[21]
7	*Increase number of mothers who know danger signs in neonates and actions to be taken*	Knowledge of life-threatening complications in newborns is low in all districts, particularly Buner. "What could be dangerous to the life of a newborn?"[22]	**Danger signs in newborn:**[23] - Difficulty feeding - Convulsions - Movement only when stimulated - Very fast breathing, >60 breaths/minute - Chest draws in when baby breathes in - Temperature >37.5 C or <35.5 C Take baby to a health facility immediately if you see any danger sign. If the health facility is far, before traveling, ask LHW to administer antibiotics if necessary.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
8	*Increase number of women who know benefits of birth spacing and how and where to access contraceptives*	One out of every five women (18%) of women in Balochistan and 14% in NWFP wish to space children.[24] Pregnant women report not wanting pregnancy because the youngest child is too young, personal health problems, poverty, or too many children.[25] Women often must rely on husbands to obtain FP.[26] Women report more communication with husbands and mothers-in-law than do husbands or mothers-in-laws (MIL) with them.[27]	Modern FP methods are safe, reliable, and reversible. Talk to your husband about planning your family. The best time to start contraceptives is six weeks after delivery, so you do not become pregnant again right away. Ask the LHW which method might work best for you. The LHW will bring contraceptives directly to your house.
9	*Increase number of women who practice exclusive BF for up to six months; who introduce solids at around six months; and who continue BF for up to two years.*	A little more than half (55%) of children under age two months are exclusively BF, while 37% of infants under age six months are exclusively BF.[2] Complementary foods are often introduced late and in too small amounts.	BF infants exclusively for at least four months and, if possible, up to six. Starting around six months, feed children freshly-prepared and nutritious semi-solid foods, while continuing to BF up to the child is two years of age or older.
10	*Increase number of women using iodized salt for the family.*	Iodine deficiencies are endemic in some parts of Pakistan.	Use salt that has iodine in it for all cooking. It will make your children healthier.
11	*Increase number of women who practice diarrhea treatment protocol for sick children: correctly prepare and administer ORS; continue to BF and give other foods; consult a health provider for severe cases.*	Around 40% of DG Khan newborns had diarrhea in the past two weeks, 35% in Upper Dir.[1] In urban squatters, ,mothers knew to give fluids during diarrhea but were unaware of the need for more food. They probably learned about fluids from the media.[28]	To treat diarrhea, mix one ORS packet with one liter boiled, then cooled water. ORS will not stop diarrhea, but will keep the body from drying out.[29] Continue to BF. Give children older than six months solid foods and other fluids, e.g., rice milk, juices. The LHW can provide treatment for child with diarrhea. Call the LHW to obtain and administer fluids for sick child.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
12	*Increase number of women who know danger signs of ARI in children and appropriate actions to be taken.*	Pneumonia is a leading cause of death for children under the age of 5 years.[30] Danger signs presumed to be not well known.	**Pneumonia danger signs** are fast breathing and difficult breathing.[31] Other symptoms of illness: looks unwell, not playing, not eating or drinking, lethargic or change in consciousness, vomiting everything, high fever.[32] If health facility is far, be sure to seek care from the LHW, who can administer antibiotics that will help stabilize child for travel to health facility.
13	*Increase number of women who provide a stimulating environment, one that promotes learning and development, for the child.*	Presumably high rates of depression among women, due to low social status and based on rates in other developing countries. Depressed mothers may find it harder to interact with children and support child development.	Message to be tailored to local situation.
HUSBANDS AND OTHER FAMILY MEMBERS			
14	*Increase number of husbands and family members who recognize pregnancy as a special condition that requires preparation, nutritious food, and rest.*	Husbands and family members perceive changes in quantity of food intake, rest, etc., but their reports are at odds with those of pregnant women. Men do not account for women's inability to control their workloads and traditional responsibilities.[33]	You have responsibilities to your wife during her pregnancy. Women need emotional and physical support during pregnancy. Discuss with the pregnant woman her concerns. If a woman has proper rest and good nutrition during pregnancy, the newborn will be healthier. Encourage woman to eat nutritious food such as eggs, milk, meat, and fresh fruit and vegetables.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
15	*Increase number of families that have a birth preparedness plan.*	Pregnancy and delivery are women's domains and men should not/do not want to be involved. Complications are of spiritual nature, not biomedical.[34]	Just as we plan for a wedding or a long journey, we must use the period of pregnancy to prepare for safe delivery of the baby and full recovery of the mother.[35]
		Primary reason for using *dai* seems to be economic, as well as traditional.[36]	Plan with the pregnant woman about where to go in case of an emergency and how she will get there. Decide who in the household will approve the decision to go to a health facility if you [husband] are unavailable. You should set aside money to pay for treatment, transport, and blood. Find out if community has emergency funds.
		Men worry that if women go to a health facility, an expensive C-section will be required.[37]	
		In some families, decisions to seek care cannot be made if the husband is absent from home.[38]	
16	*Increase number of husbands/family members who know danger signs during pregnancy, delivery and postpartum period and are aware a complicated delivery can endanger mother's and baby's lives.*	Husbands have very little knowledge of danger signs. Women's low status allows men to avoid involvement until woman is clearly in danger. Men are aware their laziness sometimes causes women's deaths. Some men do not act even when TBA makes referral.[39]	Islam emphasizes rights of women and children. You have responsibilities for your wife and newborn during pregnancy and delivery.
		Mothers-in-law say complications are result of *nazar* rather medical conditions. Female elders point out that they gave birth at home with no problem.[40]	A complicated delivery can endanger mother's and baby's lives. You must be especially watchful during this time and in hours and days following birth. If any danger signs appear, immediately take mother and/or newborn to a doctor or health facility.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
17	*Increase number of husbands/family members who feel responsible for their child's health and who know the importance of 1) Early wrapping of newborn, 2) Initiating BF soon after birth, 3) Delayed bathing of newborn, 4) Exclusive BF for six months, 5) Starting semi-solids at six months, 6) Continuing BF for two years, 7) Full immunization of child according to EPI schedule.*	See current practices under *Women of Reproductive Age.*	Baby comes from a very warm environment, so your home feels cold to baby.[41] Wrap newborn in clean cloth right after birth and place beside mother. For seven days, do not bathe baby because wetness will make baby very cold.
			BF baby soon after birth. Colostrum is the perfect first food for the newborn.
			BF infants exclusively for about six months. At about six months of age, feed child fresh, nutritious foods while continuing BF up to child is two years old or more.
			Take child for immunizations before the first birthday. If you are already at the clinic, it is safe to immunize the child while he or she is sick.[42]
18	*Increase number of husbands/family members who know danger signs for neonates and appropriate actions to be taken.*	Knowledge of complications in newborns is low in all districts, particularly Buner. "What could be dangerous to the life of a newborn?"[43]	If the crop is infested, you immediately try to identify the problem and take appropriate action. Will it help if you sprinkle pesticide after it has been destroyed? Similarly, you must observe baby for danger signs and seek timely care from trained providers.[44] **Danger signs in newborn:[45]** - Difficulty breathing - Convulsions - Movement only when stimulated - Very fast or difficult breathing, >60 breaths/per minute - Chest draws in as baby breathes in - Temperature >37.5 C or <35.5 C

No.	Sub-objective	Existing Beliefs/Practices	Message Content
19	*Increase number of husbands/family members who know danger signs for diarrhea and pneumonia in children under age 5 and appropriate actions to be taken.*	Diarrhea and pneumonia are leading causes of death of children under age the age of five years.	For diarrhea, correctly mix and administer ORS to sick child. The LHW can provide treatment for child with diarrhea. **Pneumonia danger signs** are fast breathing and difficult breathing. Other symptoms: not eating or drinking, not playing, lethargy or change in consciousness, vomiting and high fever.[8] If the health facility is far, seek care from the LHW, who can give antibiotics and/or ORS to stabilize the child for travel to a health facility.
20	*Increase the number of husbands/family members who approve of using contraceptives to space births.*	Husbands and family members strongly influence contraceptive use.	Modern FP methods are safe, reliable, and reversible. A small family is a happy, prosperous family.
COMMUNITY MEMBERS			
21	*Increase number of community leaders who actively support upgrading local MNCH services in their areas.*	Low status of women and limited community resources are barriers to making MNCH services a priority. The sense that nothing or none but God could have changed the outcome is a significant barrier.[46]	Death or illness affects the entire community. It is your responsibility to ensure the safety of each woman and child in the community. Advocate for the best possible MNCH services in your community.
22	*Increase number of community leaders who initiate MNCH activities in their communities to improve MNCH outcomes.*	Women's matters generally considered internal family affairs, not to be discussed openly outside the home.[47]	You have an important role in preventing maternal and newborn deaths. Mobilize the community to demand better services for mothers and children.
23	*Increase number of community leaders who support birth preparedness initiatives, including community saving schemes, blood donations, and transportation arrangements*	HCPs in PAIMAN districts report few community initiatives for birth preparedness.[48]	Mobilize your community to plan together for emergencies and pool funds that can be used for transportation and/or service fees. The community should do everything possible to help each woman and baby survive pregnancy and childbirth. Reassure TBAs they will not lose credibility or income for making referrals.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
24	*Increase number of community leaders who support initiatives for child health, including nutrition, immunization and appropriate treatment for common childhood illnesses.*		Ensure children's health through good nutrition, immunizations to protect them from disease, and timely care seeking for diarrhea and pneumonia. Most illnesses that cause serious problems for our children are easily treated if we take immediate action.
***ULAMA* (RELIGIOUS LEADERS)**			
25	*Increase number of ulama who discuss the importance of women's rights in Islam, including their right to healthcare during pregnancy/ delivery/postpartum period.*	Ulama have increasingly restricted their role to purely religious issues only. Health issues are seldom discussed in religious gatherings in sermons or lectures.	Islam emphasizes rights of women and mothers. Educating people about these Islamic injunctions is our duty. Women have the right to the best healthcare possible during pregnancy, delivery, and hours and days following birth. No woman should die in childbirth because of lack of healthcare.
26	*Increase number of ulama who discuss the importance of children's rights in Islam, including their right to healthcare.*		Children are a gift from God. You have prayed hard for this baby, and now it is your responsibility to care for him/her.[49] Take your child to a doctor if s/he appears to be sick. Every child, regardless of gender, needs nutritious food, immunizations to be protected from disease, and time for play and school.
27	*Increase number of ulama who discuss the importance of family planning.*	Although there is no published research on local *ulama* attitudes toward FP, generally, FP is regarded as contrary to teachings of Islam.[6]	FP is in accordance with teachings of Islam. It is proper to plan for one's family so each girl and boy has plenty of food, attention, and time for school. Every woman should have at least two years' rest between pregnancies.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
TRADITIONAL BIRTH ATTENDANTS			
28	*Increase number of TBAs who use clean delivery kits.*	Almost one-thirds (29%) of rural women who had a home birth used a CDK.[50]	CDKs help protect mother and baby from infections. The family will praise you when you show your concern for the pregnant woman by using a CDK.
29	*Increase number of TBAs who know danger signs of obstetric complications and where to refer emergencies.*	Men and women focus group discussions say *dai* are reasons for delays in seeking care, as they are the first point of contact. Men seem particularly aware of this. However, those who have experienced an emergency say TBAs did everything possible and are not to blame.[51]	Husband and family members rely on you to recognize danger signs and know when to refer the pregnant woman to a health facility.
		TBAs admit they do not know enough about pre-eclampsia and mal-presentations to be able to save women's lives.[52]	**Pregnancy danger signs:** - Vaginal bleeding - Swelling of face, hands - Severe headaches, blurry vision - Gush of fluid from vagina - No movement from baby - Persistent contractions at <37 weeks
			Delivery danger signs: - Labor lasting >12 hours - Placenta not flushed within 30 minutes of birth - Headache, fits, blurry vision - Heavy bleeding - Baby's arm, leg, or cord is the presenting part - Drowsiness, pulse >100/minute, cold skin
			Postpartum danger signs: - Excessive, heavy bleeding - High fever - Headaches, fits, blurry vision - Pain in lower abdomen - Foul-smelling vaginal discharge - Swollen or sore breasts

No.	Sub-objective	Existing Beliefs/Practices	Message Content
30	*Increase number of TBAs who know danger signs for neonates and actions to be taken if they appear to be ill.*	TBAs generally do not provide newborn checkups. They do not know danger signs, nor counsel on cord care, BF, or other basic topics.	**Danger signs in newborn:[53]** - Difficulty feeding - Convulsions - Movement only when stimulated - Very fast breathing, >60 breaths/minute - Chest draws in when baby breathes in - Temperature >37.5 C or <35.5 C
			Newborn possessing any danger sign must be taken to a health facility.
			Pneumonia danger signs are very fast breathing and difficult breathing. If the health facility is far, seek care from the LHW, who can give antibiotics to stabilize baby for travel.
31	*Increase number of MNH referrals by TBAs.*	Only 10 of 52 healthcare providers (HCPs) interviewed said they provided postpartum checkups. Only two counsel clients on need for postpartum checkups. Those interviewed were primarily community- and facility-based TBAs as well as LHVs, LHWs, and two female doctors.[54]	Hours and days following birth are women's most dangerous. You must stay with her for six hours after delivery to ensure bleeding is not excessive. You must check her again on Days 1, 3, 7, and 14 to ensure she has no fever or other signs of infection, excessive bleeding, severe headaches, or blurry vision.[55] Immediately refer a woman with danger signs to a health facility. You will increase your good community standing when you continue to provide good care for women during their postpartum period.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
FORMAL HEALTHCARE PROVIDERS			
32	*Increase number of HCPs who consider pregnancy a special time that requires special care, support, and preparedness.*	General perceptions of HCPs are they are uncaring and incompetent, particularly at government hospitals.[56]	Welcome the pregnant woman and her family members and praise them for coming. Explain you want to help the woman safely deliver a healthy baby. Explain the importance of a nutritious diet. If possible, counsel male members directly about importance of BP, or counsel any female elders in attendance.
		Doctors scored low in MNH knowledge; LHWs had much higher scores. Doctors tended to know more about neonatal than maternal health. Doctors fared better, albeit still low, than LHWs in counseling skills assessment.[1]	
33	*Increase number of HCPs who encourage clients to have a BP plan.*	HCPs (mostly *dais* were surveyed) have inadequate knowledge of what constitutes BP. About half mention transport, diet, and setting aside funds. Many do not emphasize prenatal care or vaccines.[57]	Many maternal deaths occur because families do not recognize danger signs. Describe danger signs in simple language and answer any questions.

[1] Analytical Report: Training Need Assessment of Public Sector Health Care Providers. April 2006. Department of Pediatrics and Child Health, Aga Khan University. Karachi, Pakistan.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
		Although HCPs do not adequately advise women, families, and communities about BP, they believe it is possible. They also reckon husbands could be reached through direct counseling or via elderly women. Other household men could be reached by husbands/elderly women. Poverty is seen as the biggest barrier to utilization.[58]	Help clients know the importance of preparing for an emergency. The family should save money to pay for services and develop a plan to transport the woman to a facility with emergency care. They also should identify blood donors.
			Explain the period of watchfulness does not end with the birth, but continues over hours and days following. Explain why it is necessary for the new mother to be checked during the postpartum period and develop a plan that identifies someone who can check on her.
34	*Increase number of HCPs who educate pregnant women about use of a CDK and newborn care, including early wrapping and delayed bathing of newborn.*		Proper CDK use can protect mother and baby from infection.
			Wrap baby warmly right after birth. Then mother should hold baby immediately to provide warmth.
			The vernix is baby's natural clothing, given by God for protection. Similarly, we wear clothes to protect our body and keep our clothes clean. Do not try to remove the vernix.
			Bathing can cause the baby to become chilled. Wait 7 days before bathing baby.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
35	*Increase number of HCPs who educate pregnant women and family members about danger signs in neonates and treatment decisions.*		**Danger signs in newborn:**[59] - Difficulty feeding - Convulsions - Movement only when stimulated - Very fast breathing , >60 breaths/minute - Chest draws in when baby breathes in - Temperature is >37.5 C or <35.5 C
			If danger signs occur, newborn must be taken immediately to a health facility.
			Pneumonia danger signs are very fast breathing and difficult breathing. If a health facility is far, seek care from the LHW, who can give antibiotics to stabilize baby for travel.
36	*Increase number of HCPs who counsel pregnant women about BF and feeding practices, including initiating BF soon after birth and exclusive BF for up to 6 months.*	There are slightly lower proportions of ever-breastfed children among those born in a health facility or with SBA.[60]	Exclusive BF has many health benefits for baby.
		Knowledge of BF guidelines low among medical students at Ziauddin University: Almost one-thirds (31%) are unaware that BF should be initiated immediately after birth; while more than half (58%) did not know exclusive BF should continue for 4-6 months and 14% thought colostrum should be discarded.	Every mother should initiate BF soon after birth. Colostrum is the perfect first food for baby.
			Baby should receive only breast milk for 4-6 months. At about six months, start baby on freshly-prepared and nutritious semi-solid foods along with breast milk.
37	*Increase number of HCPs who counsel pregnant women about initiating contraceptive use at six weeks postpartum.*	Many HCPs miss opportunities to counsel pregnant women on FP.	Modern FP methods are safe, reliable, and reversible. A small family is a happy, prosperous family.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
38	*Increase number of HCPs who educate the family on how to prepare and administer ORS.*		Mix one packet ORS with a liter boiled and cooled water. Continue to BF baby. Give children older than six months gruel, rice water, fruit juice, and solid foods in addition to breast milk.
			ORS does not stop diarrhea but keeps the body from drying out. Diarrhea will stop by itself.
39	*Increase number of HCPs who educate the family about ARI danger signs in a child.*		**Pneumonia danger signs** are very fast breathing and difficult breathing.[61] If these are noticed, take child to a doctor immediately.
40	*Increase number of HCPs who advise children be fully immunized according to EPI schedule.*		Immunizations are safe and protect against deadly diseases. Start immunizations at about nine months. It is safe for children to be immunized even when they are sick.[62] Ask LHW for an immunization card.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
JOURNALISTS			
41	*Increase number of journalists who report on maternal, newborn, and child health issues.*	No research available	• 22,000 women in Pakistan die each year from pregnancy-related causes. • Despite almost half of all maternal deaths occurring within 24 hours of delivery, very few women receive postpartum care. • Infant mortality rate has not improved since 2003. • Pakistan has the lowest expenditure for health (2.3% of gross domestic product) in all of Asia.12 • Inform your audiences of these facts and what can be done to prevent needless deaths of many of Pakistan's women and children. Be sure to advocate for improved MNCH services.
42	*Improve quality (fact-based, good use of expert resource persons) of MNCH coverage.*		Pakistan has many quality sources of information and data. Be sure to interview those most knowledgeable about the issues.
43	*Increase number of journalists who know a complicated delivery can endanger the baby's life.*		Delivery is a dangerous time for the newborn. Birth asphyxia, the leading cause of death of children under age 5, occurs during delivery.[63] Government's 2010 goal: To increase % of SBA-assisted births from 12% to 30% (rural) and 43% to 80% (urban).

No.	Sub-objective	Existing Beliefs/Practices	Message Content
44	*Increase number of journalists who know majority of infant and child deaths can be prevented through simple steps of exclusive BF, completing immunization, appropriate treatment of diarrhea, and timely care-seeking for ARI.*		Simple steps can of babies' and children's lives. 1) BF baby soon after birth and exclusively BF for about six months. Government's 2010 goal: To increase % of children being exclusively BF through six months from 18% to 50%.
			Immunizations are safe, available, and protect children from deadly diseases. Each child should be fully immunized. Government's 2010 goal: To increase immunization coverage to 100%.
			Diarrhea and pneumonia are major causes of child death. Diarrhea can be treated at home with ORS, continued giving of food, and increase of fluids to prevent dehydration. Pneumonia and ARI can be easily treated at a health facility.
***NAZIMS* AND PARLIAMENTARIANS**			
45	*Increase number of nazims who support women's maternal, newborn and child health initiatives by devoting more resources*	Pakistan has the lowest expenditure (2.3% of GDP for health in all of Asia.[64] There is only 1 hospital for >170,000 persons; 1 rural health centre for >184,000; 1 basic health unit for >19,000; and 1 MCH center for >4,400 pregnant mothers.[65]	Ensuring mothers' and newborns' health is a major GOP priority. More resources should be allocated for MNCH services. It is your responsibility to do everything you can to improve services for mothers and children.
		Health facilities are understaffed and have no female doctors. Primary facilities lack basic equipment. Basic Health Units lack antiseptic supplies.	
46	*Increase number of parliamentarians who advocate MNCH issues.*		You will be recognized for your leadership when you advocate for better MNCH care.

No.	Sub-objective	Existing Beliefs/Practices	Message Content
DISTRICT, PROVINCIAL, AND FEDERAL BUREAUCRATS			
47	*Increase number of officials who support MNCH initiatives by devoting more resources.*	Same as above.	It is your responsibility to do everything you can to improve services for mothers, newborns and children. Allocate resources necessary to safeguard mothers', children's and babies' lives.
48	*Increase number of officials who advocate MNCH with fellow bureaucrats.*		Improving women's health will increase your communities' goodwill and support. Ensure client-centered services at all public health facilities.

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