Ministry of Health
WasaaradaCaafimaadka Puntland

Behavior Change Communication Strategy For Maternal, Neonatal and Child Health In Karkaar Region Of Puntland, Somalia.

Health Consortium Somalia Project.

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Save the Children

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
BCC	Behaviour Change Communication
CHW	Community Health Workers
DFID	Department for International Development
DPT	Diphtheria Pertussis and Tetanus
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
IEC	Information Education and Communication
IUD	Intra Uterine Device
KAP	Knowledge Attitude and Practice
KII	Key Informant Interview
MCH	Maternal and Child Health
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organisations
OPV	Oral polio vaccine
PPS	probability proportional to size
SCI	Save the Children, international
SPSS	Statistical Package of Social Sciences
TBA	Traditional Birth Attendants
THET	Tropical Health and Education Trust
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
WHO	World Health Organization
MICS	Multiple Indicator Cluster Survey

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We sincerely hope this document serves its purpose of increasing awareness at all levels and subsequently improve the utilization of health care services in the region.

1 INTRODUCTION

1.1.1. Geographical and Political Context

Somalia is a coastal country covering a land area of 637,657 square kilometres in the Horn of Africa bordering Kenya in the south, Ethiopia in the west, Djibouti in the north, and in the east it faces the Gulf of Aden and the Indian Ocean. The country is geographically and politically divided into the three zones of South Central Somalia, Somaliland (the north-west) and Puntland (the north-east). These zones are further divided into a total of 18 administrative regions. The current size of the population is unknown, since the last census was performed 40 years ago, in the early 1970s. Estimates range from 6 million to 11 million. The official United Nations estimate, however, is 8.9 million[1].Some 70 per cent of the population live in South Central Somalia, while 20 per cent are resident in Somaliland and 10 per cent in Puntland. According to estimates, one third of the population live in urban areas and two thirds in rural areas. The rural population can be divided, partly based on their livelihood, into pastoralists, agro-pastoralists and riverine populations.

Politically, Somalia is considered the world's most fragile state[2] characterised by over two decades of conflict and civil unrest. A combination of war and natural calamities, such as the 2011 drought and famine, has taken the lives of hundreds of thousands Somalis and left many more destitute. The United Nations High Commissioner for Refugees (UNHCR) estimates[3] that over 1.36 million Somalis are internally displaced.

1.1.2. Maternal and Child Health Situation

Situation analysis and surveys conducted in recent years illustrate appalling picture of acute and chronic maternal and child health needs that compare with no other in the world. Statistics speak of severe suffering and death. For instance, the maternal mortality ratio is strikingly high at 1,000 – 1,400 maternal deaths per 100,000 live births[4]. Giving birth remains one of the greatest risks in the lives of Somali women given the life-time risk of dying due to pregnancy related causes is approximately 1 in 14.[5] Over 90 per cent of Somali women give birth at home under the care of unskilled attendant. Less than 10 per cent births are attended by skilled personnel[6].

On average, Somali women have more than six children during their lifetime, a direct result of only one percent of the population using modern contraception and over 25 per cent of all women have an unmet need for family planning.[7] Female genital mutilation/ cutting (FGM/C) is almost universal and is performed on young and adolescent girls.[8]

1 UNICEF (2009) The State of the World's Children – Special Edition 2009
2 Failed States Index, http://www.foreignpolicy.com/failedstates
3 UNHCR estimates, July 2012
4 Maternal Mortality Estimates, WHO, UNICEF and UNFPA, 2010
5 UNICEF 2011 Annual Report
6 Somalia Child Health Strategy, draft
7 UNICEF MICS, 2006
8 Somalia Reproductive Health Strategy, UNICEF 2009

Childhood immunization coverage (one year olds fully immunized) was only 36 per cent in 2007, according to the joint administrative report of UNICEF/WHO. According to the same report, only 18 percent of women received two doses of tetanus toxoid during their last pregnancy. The WHO estimates the perinatal mortality and under five mortality rates in Somalia at 81 per 1,000 total births[9]and 200 per 1000 live births respectively. The main causes of newborn deaths in Somalia are low birth weight and premature birth, asphyxia, birth injuries, septicemia and neonatal tetanus while the main causes for under-5 mortality are pneumonia (24%), diarrhoea (19%), neonatal disorders (17%), and measles (12%)[10]. In spite of high disease burden and extreme child mortality rates, there is a very low demand for public health services. Data from UNICEF reveals that Somali children under the age of five visit an MCH clinic every fourth year[11]. Other data show that only four percent of children with suspected pneumonia were taken to an MCH clinic, while 17 per cent got a remedy straight from the private pharmacy and as many as 70 per cent were left without any intervention[12].

These statistics provide only a glimpse into the shocking health situation in Somalia where in the backdrop of protracted conflict, the crumbled health system is struggling to provide even the most basic services. The health system is exemplified by dilapidated infrastructure, inadequate supplies, few health workers with inadequate skills, operational fragmentation among many more challenges.

1.1.3. Maternal and Child Health Interventions

The Ministry of health and a number of partners have been engaged in promoting maternal and child health in Somali. These partners include, but not limited to: World Vision, Merlin, UNICEF, Save the Children among others. Save the Children has over 20 years' experience of supporting the health sector in Somalia, with a focus on delivering primary healthcare to communities affected by the longstanding humanitarian crisis. The organisation's intervention approach is providing emergency relief as well as health systems support with a longer-term focus.

In the north eastern zone of Puntland, Save the Children has been engaged in a number of support areas ranging from providing local technical capacity at service delivery points to a broader health system strengthening at central level. At community level, Save the Children works within community structures and building relationship between them and health facilities. In Karkaar region Save the Children is currently implementing a two-year DFID-funded maternal and child health focused project[13] aimed at improving the capacity of the Ministry of Health and the health workforce to provide, manage, and monitor quality health services at primary level while at the same time working towards increasing health service utilization by the local communities. The later involves reaching out to communities with appropriate health promotional messages, addressing barriers and enhancing awareness on seeking health care. The project is part of a broader consortium bringing together Population Services International (lead), Save the Children, Trócaire, Health Poverty Action and THET. The consortium aims to rollout essential package of health services by harnessing the specific and complimentary thematic strengths of each agency and learning from each other.

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9 WHO Somalia Country Profile, 2007 http://www.emro.who.int/somalia
10 WHO (2009). World Health Statistics 2009: Cause-specific mortality and morbidity
11 UNICEF (2008). Exploring Primary Health Care in Somalia - MCH Data, Somalia 2007
12 UNICEF Somalia (2006). MICS Somalia 2006
13 Titled: *Harmonizing Support to Somalia Maternal and Child Health Program*

1.2.1. Purpose of the Behaviour Change Communication Strategy

The Behaviour Change Communication (BCC) strategy will be used to plan and implement advocacy, communication and social mobilization activities in order to increase knowledge and utilization of health services for improved health outcomes of the target population in reducing child and maternal mortality in Puntland, Somalia.

1.2.2. Process of BCC Strategy Development

Evidence based approach informed the development of this strategy. A KAPs assessment was conducted to generate information that was used to develop this Behaviour Change Communication (BCC) strategy and communication messages on maternal and children health in order to increase knowledge and utilization of health services for improved health outcomes (reduction in child and maternal mortality) in the target population. The KAPS assessment was conducted from 2nd to 7th September 2012 in all the five districts of Karkaar region of Puntland.

Following the KAPs survey, a BCC consultative workshop was held in Garowe, Puntland on 19th to 21st November 2012 to develop the strategy based on the KAPS assessment findings. The consultative meeting identified the key message content for each target group on MCH issues. Participation was from the MOH at national and regional level, MCH partner that include WHO, UNFPA, Merlin, SRCS, health teaching institutes and other local organizations as well as health care providers from different health facilities.

1.2.3. Moving beyond individual behaviours to social conditions and social relationships

The approaches that are used in this strategy are adapted from the Socio-ecological model[14], which is a newer BCC theory that recognises that individuals respond to messages and information, however there is need to consider social conditions and social relationships that facilitate and reinforce or in some cases inhibit health behaviour. This model acknowledges that behaviour is a function of person and its environment. Socio Ecological model combines psychological and social theoretical perspectives to shift our conceptual thinking to a more holistic level. It has been applied at the various levels of analysis to develop the audience profiles and segments as well as channel mix, approaches, and other cross cutting issues like designing information, skills needed, norms, motivations among others. The thinking behind this model is that simply addressing individual behaviour is not enough.

This strategy also lays emphasis on 'communication as dialogue', where influence flows in both directions. Both the sender and receiver influence each other. Neither one is a passive recipient of information; both are communicators capable of processing information and engaging others in dialogue. Therefore, the strategies recommended are designed to enhance dialogue among the target audiences and change agents in an effort to create understanding on the various underlying MCH issues and solutions. This is because simply giving correct information, 'while' important, does not change behaviour by itself.

14 Socio Ecological model: adapted from C-Change 2010 . C-Modules: a learning package for Social and Behaviour Change Communication. Washington, DC. AED/C-Change

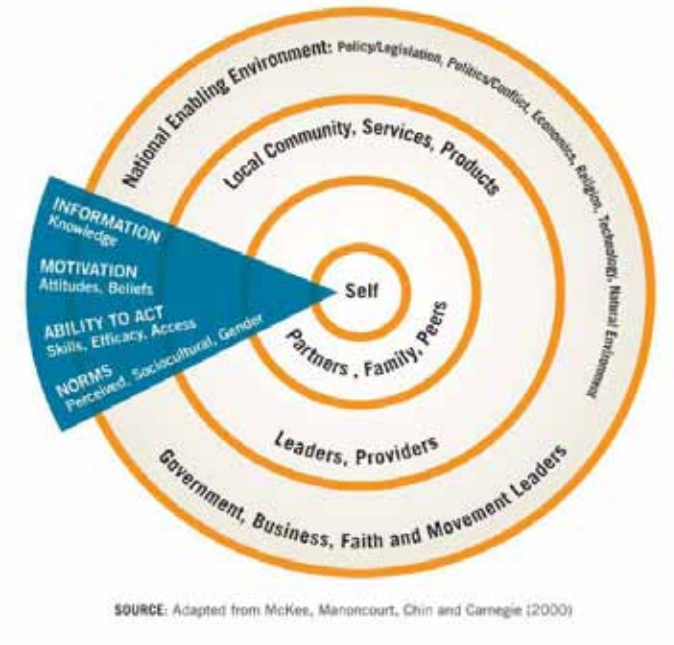

Figure 1: Socio-ecological model

1.2.4. MCH BCC Strategy in the Context of EPHS and Puntland Health Strategic Plan

This strategy is consistent with the policy documents developed to guide Essential Package of Health Services (EPHS) services[15] in Puntland Somalia. The EPHS has identified maternal, reproductive and neonatal health including child health as two of the ten programmes identified that is offered at all the four levels of service delivery. These four levels include; primary health unit (PHU), health centre (HC), referral health centre (RHC) and hospital (H).

The EPHS report further states that a particular focus on the provision of essential levels of service to women and neonates is important as well as effective referral between tiers of service.
The BCC strategy for MCH has been developed to strengthen and compliment the services offered at these levels as well as support demand creation and utilization at all levels. It is expected to stimulate dialogue at the community level through the primary health units and use other existing structures to encourage key MCH practices. The primary health unit which is staffed by a community health worker (CHW) and supported by an elected representative of the community health committee (CHC) will be fully equipped on MCH health promotion and practices.

The EPHS recommends the use of Community Health Promoters (CHP) who would be volunteers with a purely promotional and mobilising role within communities. Their point of contact would be the Primary Health Units. Based on this recommendation, this strategy has been designed to address this need for community mobilization to action and stir up dialogue on MCH issues.

15 Essential package of health services report , Somalia 2009

According to the EPHS report, Traditional Birth Attendants (TBAs) cannot be formalised into the human resources of the health plan. The recommendation given is to transform TBAs into other roles such as CHWs or health promoters or to be given small incentives for bringing women to health centres for ANC and delivery. This BCC strategy takes cognisance of the crucial role of TBAs in MCH and hence has further incorporated a component to empower them to be partners in health. However, it is important to incentivise them particularly in health facility referral regarding delivery.

According to the human resource development profile and cadres in the health system presented by the EPHS report, there exists a gap for health promotion officers' cadre. For sustainability purposes, this BCC strategy recommends inclusion of health promotion cadre in the health system. This specific recommendation can be addressed through the human resources for health strategy of the health sector strategic plan which outlines the need to establish a skilled, well managed, motivated and equitably distributed workforce to provide EPHS. This cadre can be introduced and a health promotion training course developed to equip the participants appropriately to deliver the EPHS.

According to the health sector strategic plan, 'there is virtually no health information and health promotion program', which can be partly attributed to a lack of health promotion experts in the Ministry of Health who can be instrumental in ensuring that health promotion remains an important agenda.

1.2.5. KAPS Assessment

Survey Methodology

A Cross-sectional descriptive study design was utilized with a sample size of 422 households. Two-stage cluster random sampling method was used, where the primary sampling units were villages and secondary sampling unit were households within the sampled villages. All the five districts within Karkar region were represented in the sampling frame. At both stages, a simple random sample was picked based on probability proportional to size (PPS) thus ensuring villages with bigger populations had more sampled households. A structured questionnaire was used to collect data from a household representative.

The recruitment of key informants and focus group discussions was purposive. Key informants included regional health officer, health workers, religious leaders, and TBAs). Key informants guides were used to lead the discussions. Focus group discussions were done with adult women and men and male and female youths.

Key Findings

- **Water and sanitation:** While majority of respondents understood the importance of the use of clean water and proper sanitation the practice of the same was not universal. Water treatment both for household use and drinking was low with 76% of households not treating their water. 30% of households do not have a toilet and therefore used open fields, bushes or shared with other families. While Hand washing appreciated by many respondents to be crucial however, the lack of information on the critical times to do so was evident.
- **Ownership and use of ITN:** Majority (75.4%) of the households surveyed did not own a mosquito net. In terms of usage, it was evident that children were not the priority group (18% children as net users). Of significant concern is that among households with mosquito nets 37% reported that no one slept under the net the previous night.
- **Birth Spacing and use of contraceptives:** There was clear evidence from both genders that knowl-

edge on long term methods of birth spacing was minimal, if not lacking, with both male and females recording less than 5% for IUDs, sterilization and implants. There is significant awareness of breast-feeding as birth spacing method which was supported by religious and cultural beliefs.

- Uptake of antenatal care services: while majority (70%) of women reported to have taken up antenatal care services during their last pregnancy, majority did not do so during their first trimester (only 43% of the respondents made their first ANC visit within the first trimester).

- Facility based deliveries: Majority (59%) of women reported to have given birth at home. This provided an explanation as to why a high proportion (44%) of women reported having experienced one or more of the danger symptoms during their last pregnancy. 29% of women who have ever been pregnant reported either having ever had a miscarriage, spontaneous abortion or still birth or a child that died after birth.

- Newborn care: Over half of the children had suffered a cough, fast or difficult breathing, which are indicative of respiratory tract infections (and commonly pneumonia). Fever and diarrhea were reported in 43% and 26% of the children respectively. Knowledge on oral rehydration for managing diarrhoea was sub-optimal with only 37% of diarrhoeal children given more fluids than usual. Slightly less than half sought treatment/advice for their sick child the same day with reasons given for the lack of prompt action to: cost (36%), long distance (28%), thought the illness was not serious (21%) and no reason (13%).

- Immunization coverage: Defaulter rate was very high (over 50%). The reasons given for not having child immunized depicted lack of adequate knowledge or poor attitude towards immunization by the parent/caretaker.

- Breastfeeding: 29% of women respondents reported not to have breastfed within the recommended one hour with reasons ranging from: 71%, perception that the mother was unwell after delivery and needed time to recover before breastfeeding; early initiation of breastfeeding being a taboo, misconception that colostrum was not good for baby and the notion that breasts had no milk at the early stage. Exclusive breastfeeding is also poorly practiced.

- Behaviour Change Communication (BCC) on MNCH : In the three months preceding the assessment, slightly less than half (46%) of women respondents heard or read messages on health of mothers and children. Health workers, radio, CHWs, NGOs and religious leaders are the most trusted sources of health information. Oral communication is more popular. This is also consistent with the fact that literacy levels are very low as demonstrated by the finding that a vast majority had not attended any formal schooling.

RECOMMENDATIONS

Based on the findings of the KAP survey and review of relevant literature, the following are the specific recommendations:

Recommendations' targeting communities knowledge and practices on MNCH

- Awareness on importance of antenatal care need to be elaborated to all women of reproductive age and especially the need for early visits, within the first trimester, and ensuring the recommended four visits of focused antenatal care.

- There is need for education also on the several danger signs in pregnancy and new-borns. Men

should also be sensitized on this and the urgent need to seek advice treatment from health facilities as soon as possible.

- All actors in Puntland should raise awareness of the harmful effects of certain practices that endanger maternal, new-born and child health including early marriages and pregnancy, female genital mutilation (FGM) among others.
- There is need for concerted efforts to educate communities on hand washing techniques and the critical times for hand washing, especially after visiting the toilets and changing babies' nappies.
- The importance of skilled attendance at birth need be a critical aspect in all MNCH campaigns targeting both men and women. Messages in this regard should be a priority so as to start addressing the high pregnancy and birth-related complications and mortalities.
- There is need for a campaign against misconception surrounding early initiation of breastfeeding. The campaign should tackle the misconceptions associated with breastfeeding.
- There is need to tackle the low vaccination uptake and especially educate communities against the notion that vaccines are not safe to new-borns or the idea that children who are not sick should not be vaccinated.
- Behaviour change communication messages should aim to raise awareness on oral rehydration of diarrhoeal children as well as the benefits of micronutrients supplementation for children especially Vitamin A
- Communities must be educated on critical benefits of family planning/ birth spacing. The Programmes should prioritize awareness on the various methods of birth spacing, especially long term methods. The strategies adopted must consider the cultural and religious sensitivities elicited by the issue of family planning.

Recommendations to improve the health system response to MNCH needs

- Health facilities as channels of delivering MNCH messages need to be enhanced given they were listed as the most trusted source and the fact that health professionals are more likely to disseminate correct and factual messages.
- The inherent dangers of over-the-counter drugs and self-medication especially during pregnancy and for a sick child need to be highlighted, both to policy makers and the consumers themselves.
- More female midwives need to be trained to not only address the health worker shortage but also meet the preference by women for female providers of reproductive and maternal health services.
- There is need to equip health facilities to deal with deliveries. Medical supplies and drugs need be made adequate so that health facilities do not become the impediment to skilled deliveries.

Recommendations touching on general health programming

- It is recommended that health programming be informed through gender analysis and any interventional actions are gender sensitive and responsive to the needs of women, girls, boys and men. It is important to emphasize that programming should ensure the specific needs of adolescents are included.

- Combination of both health facility-based and community-based approaches will be required to increase MNCH service uptake. Community Health Workers, Traditional Birth Attendants, Traditional healers and any other 'alternative' healthcare providers must be seen as partners rather than competitors.

Recommendations on proper and effective channels of information on MNCH

- Behaviour change communication initiatives in the project area should use a mix of channels with more focus on oral means of communication especially counselling and interpersonal communication by health workers (both formal and CHWs) and radios. As mentioned earlier, it is prudent to undertake more analysis of radio as a means of communication. Given the high diffusion rate of information (from person to person) influential opinion shapers should be identified and engaged as agents of behaviour change.

2 BCC COMMUNICATION STRATEGY

2.1.1. BCC Strategy Goal

The goal of this strategy is to provide the road map on planning, implementation and monitoring of BCC MCH interventions to support the achievement of the EPHS core program areas of maternal, reproductive, neonatal and child health priorities. It aims at specifying priority behaviours to promote at the different levels of service provision. All this is aimed at contributing to the vision of the health sector strategic plan of having all people in Puntland enjoy equitable and quality health services.

2.1.2. Key BCC Strategies used

To achieve the goal outlined above, four key strategies will be strategically interlinked to bring about the effective communication aimed at MCH behaviour change and disease prevention. These strategies are advocacy, behaviour change and communication, and social mobilization. In addition capacity strengthening for health promotion and behaviour change will be conducted. However the success in demand creation and utilization of the services through the broad strategies will directly be linked to availability of services, products and proper planning. The figure below shows the four broad strategies that will be used in an integrated manner in implementation of BCC interventions in Puntland.

1. **Strategy One:** Behaviour Change And Communication targeting the individuals and communities to change knowledge, attitudes and practices on maternal and child health through multiple channels and participatory approaches appropriate to the Somalia region.

2. **Strategy Two:** Advocacy among policy and decision makers to build political and social commitment for maternal and child health programming, including advocacy for resource commitment. This BCC strategy will be instrumental in advocating for a financing system that relies more on National financing and local resources as well as financing that is aligned to the National priorities[16] particularly as it regards MCH.

3. **Strategy Three:** Social Mobilization for partnership and alliances in maternal and child health programs, including private and public partnerships and mass media mobilization.

4. **Strategy Four:** Capacity Strengthening on health promotion and BCC of Health Workers, Community Health Promoters, Community Health Workers and Traditional Birth attendants. There should be special focus on advocating for inclusion of health promotion cadre in the health system and creating a course to effectively equip this cadre in delivering priority health promotion targets which include MCH.

16 Draft Puntland Health Sector Strategic Plan 2013 - 2016

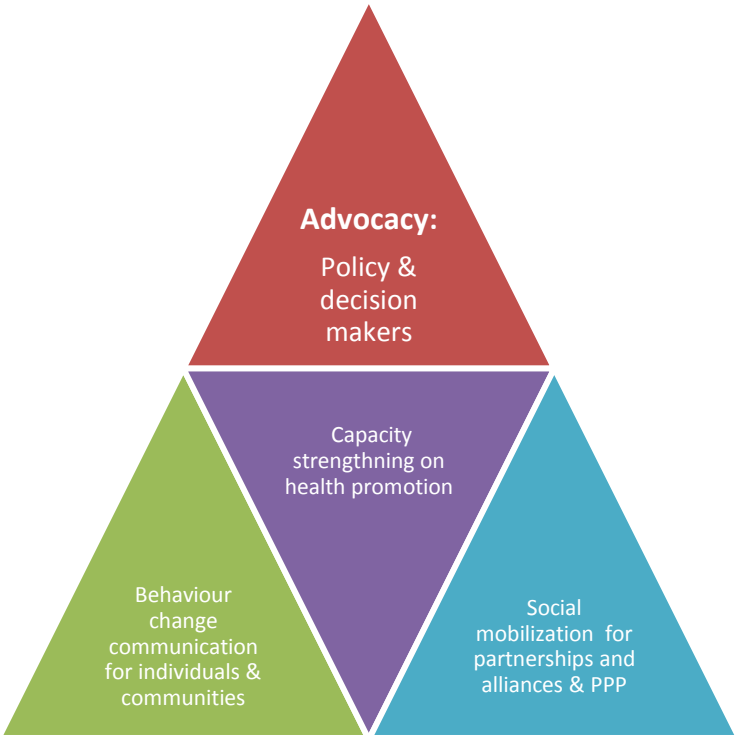

Figure 2: MCH BCC approaches

3 STRATEGY ONE: BEHAVIOUR CHANGE AND COMMUNICATION FOR MCH

Behaviour change and communication is designed to target the individuals and communities to change knowledge, attitudes and practices on MCH. This section addresses the behaviour change issues related to priority MCH services that include: antenatal care (ANC) pregnancy and pre-pregnancy), delivery and intre-partum (delivery up to 2 weeks), post natal and child health issues. Each of the categories is discussed separately in terms of target audiences, communication matrix, barriers, and key communication messages.

3.1. Antenatal Care (pre-pregnancy and pregnancy)

The following key practices are addressed under this section: demand and utilization of ANC services, utilization of skilled attendants and danger signs in pregnancy.

3.1.1. Target audiences for key antenatal care services

This section presents an analysis of the different targeted audiences for antenatal care. The target audience analysis is categorised into two: primary audience and secondary audience. The primary audience are people most affected by the issues or problems. The second category is the secondary audience comprised of people directly influencing the most affected. Lastly we have the tertiary audience which is a segment of the people who indirectly influence the behaviour of the most affected people. This specific category will be tackled under the advocacy section.

Target audiences for Antenatal care services

Table 1: Target audiences for antenatal care services

STAGE	AUDIENCES	SEGMENTS
Ante-Natal Care	Primary audience (Most affected)	• Pregnant women • Women of reproductive age
	Secondary audience (Directly influencing)	• Husbands • Traditional birth attendants • Men of reproductive age • Health service providers • Grandmothers, in-laws

3.1.2. . Communication matrix for ante-natal care services

This section provides a description of the MCH key practices clustered under the ante-natal care services. From the KAPS assessment the following are the key current practices:

1. **ANC Visits:** Delay in taking up ANC services and very few pregnant mothers go for at least four ANC visits during their pregnancy.
2. **Danger signs in pregnancy:** Lack of knowledge on danger signs during pregnancy and failure to seek prompt treatment from health facility
3. **Ownership and use of nets:** Majority of households do not use mosquito nets and children were not the priority.

The table below provides an analysis of the above issues from the KAPs assessment and consultative meeting. It clearly states the desired behaviour, the channel mix, tools and materials, the barriers to ideal practice and key communication messages related to the practices.

Communication Matrix for Ante-Natal Care (Pre-Pregnancy And Pregnancy)

Table 2: Communication matrix for antenatal care (pre-pregnancy and pregnancy)

Desired changes	Channel mix	Tools and materials
At Least 4 ANC Visits • Increased utilization of ANC services, at least 4 ANC visits during pregnancy • Accept and seek IPT during pregnancy • Sleep under an LLIN every night **Skilled Attendant** • Increased utilization of skilled attendants at health facility. • Increased number of pregnant women with a birth preparedness plan. • Increased number of pregnant women planning to deliver in a health facility and have made arrangements for emergency transport **Danger Signs In Pregnancy** • Increased number of pregnant women seeking prompt care when you see danger signs in pregnancy	**Mass media** • Radio programs especially interactive sessions with questions and answers **Community based** • Community health workers home visits • Mother support groups • Dialogue with Traditional birth attendants and health providers. • Community meetings and groups • Faith based networks • Drama and debates	• Radio spots • Printed posters and fliers • Community health workers flip chart • Dialogue cards • Job aid for health workers • Community outreach Dramas. • Regular ME & MOTHERS sessions at health facilities. • Community dialogue sessions(All inclusive in open area)

3.1.3 Barriers to achieving desired behaviours

- Lack of knowledge about benefits of ANC visits by different target groups
- Long distance to health facilities and lack of transport
  Cost of giving birth in health facilities including transport, cost of hospital stay
- Health workers lack the interpersonal communication skills to effectively deliver the required services
- Lack of knowledge on benefits of visiting health post within 2 days of home delivery
- Lack of adequate investment on the infrastructure to provide ANC services
- Lack of sufficient supplies and commodities for skilled attendants
- Lack of knowledge about benefits of skilled attendants during delivery
- Lack of knowledge about danger signs and warnings during pregnancy. Some mothers did nothing about the dangers, some sought treatment from TBAs, and others purchased medicine from shops/ pharmacy
- Lack of linkage between TBAs and health facility
- Some mothers are uncomfortable with male nurse attendants
- Lack of preparation for emergency transport
- Delivery at home is also influenced by lack 'someone to take care of the other children'
- Lack of knowledge on use and benefits of ITNs for malaria prevention
- Ineffective coordination of MCH programs including IPT

3.1.4. Key ANC communication messages

- Seek at least a minimum of four ANC visits during pregnancy at the health facility. You will receive counselling and testing on HIV, Iron and folate tablets, tetanus toxoid injection and general check up on illnesses
- Seek ANC services as soon as you know you are pregnant
- Develop a birth plan and have emergency plans like money, transport
- Plan to deliver your baby in the health facility because it is risky to deliver at home, you may get birth complications
- Seek prompt care from the health provider as soon as you see any danger signs like convulsions, severe headache, lower abdominal pains, pain urinating continuous vomiting and heartburn, no movement of baby, welling of face and hands, bleeding from private parts
- Eat a balanced diet and rest more

MY STORY

On the 23rd of June 2011, my first baby was delivered by a TBA at home. The baby experienced breathing complications. She was rushed to hospital at this critical time but died on the way to hospital. It is about one kilometer from home to a health facility. In the following year may 16th 2012, the second baby was due and my wife was experiencing labour. There was great pressure to have her delivered under the care of a TBA. I totally refused, hired a taxi and rushed her to hospital. She was delivered by a skilled health provider at mid night. The baby had similar breathing complications, but fortunately we were in the hospital and the doctor attended to her using the oxygen machine. The baby survived and is very healthy now. Since this experience, I have become a big advocate of hospital delivery. I provide health education at health facilities; just recently I trained 150 mothers on the importance of hospital delivery. As a man I have a big role in ensuring the health of my wife and children. Abdi (not his real name, project officer in one of the INGOs.)

3.2. Delivery, Intre-Partum And Post Natal Care

This section addresses the target audiences for intre-partum and post natal care. It further provides an analysis of the desired changes, channel mix and tools and materials required conduct BCC on intre-partum and post natal. Barriers to achieving desired behaviours are discussed including key messages to the target audiences.

3.2.1. Target audiences for intraepartum and post natal care period.

Table 3: Target audiences for intraepartum and post natal care period

STAGE	AUDIENCES	SEGMENTS
Delivery And Intra-Partum Care	Primary audience (Most affected)	• Pregnant women and mothers with new-borns up to 2 weeks
	Secondary audience (Directly influencing)	• Traditional birth attendants • Husbands • Health service providers • Community leaders • Community gatekeepers and opinion leaders: elders and Imams • Women groups and other social networks

STAGE	AUDIENCES	SEGMENTS
Post Natal	Primary audience (Most affected)	• Caregivers in households with children less than five years. • Lactating mothers
	Secondary audience (Directly influencing)	• Traditional birth attendants • Husbands • Health service providers • Community leaders • Community gatekeepers and opinion leaders: elders and Imams • Women groups and other social networks

3.2.2. Communication matrix for key practices on intra-partum and post natal for BCC

The key practices from the KAPS assessment to be addressed under intrae-partum and post natal are as follows:

1. **Birth spacing**: Lack of knowledge on benefits of long term birth spacing methods coupled with negative religious, cultural and traditional beliefs
2. **Danger signs in new-borns:** Lack of knowledge on the danger signs in new-borns as well lack of knowledge on new-born care

The table below provides an analysis of the above issues from the KAPs assessment and consultative meetings. It clearly states the desired behaviour, the channel mix, the key barriers to ideal practice and key messages related to the three key areas.

Communication Matrix for Intrae-partum and post natal for BCC

Table 4: Communication matrix for Intrae-partum

Desired changes	Channel mix	Tools and materials
Immediate New-born Care • Increase in number of mothers who delay the baby's bath for 24 hours • Increase in number of mothers who place the baby skin to skin to keep warm • Initiate breastfeeding within 30 minutes of delivery • Visit a health facility within 2 days if you deliver at home	**Mass media** • Radio program with interactive sessions and call in questions and answers **Community based** • Community health workers household visits and interpersonal communication • Me and mother groups • Dialogue with Traditional birth attendants • Dialogue with traditional healers • Dialogue with religious leaders and elders	• Radio spots and radio scripts for MCH programs • Posters on new born care issues • Community health workers flip chart and counselling cards • Dialogue cards for TBAs • Job aid for health workers on specific new born issues • Health worker talks to mothers at MCH • Leaflets distribution • Policy direction letters from MOH
Danger Signs In Babies • Increase in the number of mothers who are able to identify danger signs in babies and they seek immediate care in a health facility		
Birth Spacing And Timing /Family Planning • Increases utilization of family planning services • Increase utilization of modern family planning methods		

3.2.3. Barriers to achieving desired behaviours

New born care

- Lack of knowledge on importance of colostrum in milk, there is a perception that it is not good for the baby
- Perception that the mother is unwell immediately after delivery and she needed time to recover before breastfeeding
- Perception that breast milk does not produce milk within first hour
- Myths and misconceptions on early initiation of breastfeeding
- Lack of knowledge on symptoms of danger signs
- Lack of knowledge on benefits of delaying baby's bath for first 24 hours
- Fear that that she will be blamed by health worker for failing to deliver in hospital

- Secretive nature of TBAs activities (they do not want interference) and poor referral culture
- The stay at home practice where referral is done only when the condition worsens
- Negative cultural beliefs on skin to skin care for babies

Family planning/Birth spacing

- Lack of information on modern family planning methods especially long acting methods
- Misconceptions and myths about effectiveness
- Over reliance of natural methods for family planning like breastfeeding
- Lacking information on where to get FP methods
- Cultural and religious barriers
- Beliefs that men always want to get more children to protect themselves in conflict
- Condoms is a taboo subject in the Islam religion
- Beliefs and perceptions that FP methods stop reproduction ability and reduces number of their children

> *"...child spacing is something which has its roots in Islam because our religion says that the baby should be breastfeed for two years so he can benefit from the milk but so that there is space between the children and we as religious leaders promote it."*
>
> Imam (Key informant)

- Belief that the more children you have, the more ownership of natural resources including land

Danger signs in babies

- Lack of knowledge on danger signs in babies
- Lack of knowledge on danger signs in babies among TBAs

3.2.4. Key Inter-partum and post natal communication messages

New born care

- Ensure warmth and keep the baby's head warm. Dry the baby immediately after delivery and wrap in a clean dry cloth
- Delay the baby's bath for the first 24 hours
- If pre-term do skin to skin care
- Breastfeed the baby within 30 minutes of delivery
- Encourage good latch
- Seek immediate care in a health facility if you notice the following danger signs; difficulty breathing and chest thumping, not feeding properly, too hot or too cold, red cord stump with pus, eyes with pus

Family planning/Birth spacing

- Space your births at least 2 years apart it is beneficial for you and the child
- Use modern contraceptives especially long acting family planning methods

3.3. CHILD HEALTH ISSUES

This section addresses the child health issues that include the following; breastfeeding, immunization, diarrhoea, hand washing, safe water, use of LLIN, hygiene and sanitation. The target audiences, desired changes, channel mix, materials and tools are discussed. In addition to these analyses the barriers to achieving desired behaviour as well as key messages are highlighted.

3.3.1. Target audiences for child health issues

Table 5: Target audiences for child health issues

STAGE	AUDIENCES	SEGMENTS
Child Health	Primary audience (Most affected)	• Caregivers in households with children less than five years.
	Secondary audience (Directly influencing)	• Guardians, parents, siblings • Health service providers • Community leaders, opinion leaders & social networks • Community gatekeepers and opinion leaders • Caregivers, Teachers, Guardians

According to the KAPS assessment, the following key practices were identified on child health issues:

- Low rate of exclusive breastfeeding of infants from 0 to 6 months
- Low immunization coverage
- Poor health seeking behaviour regarding diarrhoea
- Low rate of caregivers practicing hand washing at four critical times
- Low rate of households that treat water for drinking
- Low latrine use
- Low ownership and uptake of ITN net use

3.3.2. Communication matrix for child health issues

Table 6: Communication matrix for child health issues

Desired changes	Channel mix	Tools and materials
Exclusive Breastfeeding • Increased number of mothers who start breastfeeding within 30 minutes of delivery • Increased number of mothers who exclusively breastfeed up to 6 months	**Mass media** • Radio • Print materials **Community based** • Community health workers education at PHU • CHWs and Community health promoters conducting; • ME and MOTHERS sessions at health facilities. • Dialogue groups with Traditional birth attendants • Community networks & meetings • Community meetings with elders and local administration • Community meetings with Imams	• Radio spots • Posters • Community health workers flip chart • Dialogue cards • Job aid for health workers
Complimentary Feeding • Increased number of mothers introducing enriched foods to your child at 6 months in addition to breast milk		
Immunization • Increased number of caregivers taking babies for immunization according to schedule within first year • Full course of immunization before first birthday (Polio, TB, measles)		
Diarrhoea Management • Increased number of caregivers seeking prompt treatment for diarrhoea		
Hand washing • Increased number of caregivers reporting hand washing practice at 4 critical points		
Safe Water • Increased number of caregivers treating drinking water		
Use Of LLIN • Increased number of caregivers and children who sleep under an LLIN every night • Increased number of caregivers who can recognise and seek early treatment for malaria		
Hygiene And Sanitation • Increased number of caregivers and children who use latrines		

3.3.3. Barriers to achieving the desired behaviour

- Cultural practices of giving the baby 'fax' a mixture of sugar and water to make the baby sweet.
- Promotions on baby milk formula by international companies
- Lack of adequate information on importance of immunization and completion of all the doses
- Lack of immunization supplies
- Lack of follow up on immunization dropout and defaulters
- Inability of mothers to access information at health facilities because of low utilization for these facilities
- Inadequate skills and knowledge among community health workers and traditional birth attendants on immunization services
- High illiteracy levels
- Negative health provider attitudes
- Cost of treatment
- Belief that breast milk is not enough
- Belief that mother will grow older when breastfeeding up to 6 months

Hand washing, safe water, sanitation

- Lack of knowledge on benefits of hand washing with soap
- Lack of household water treatment products
- Lack of knowledge on benefits of toilets
- Limited access to portable water

3.3.4. Key child health Messages

a. Breastfeeding

- Start breastfeeding immediately after birth within 30 minutes. This milk has colostrum, which is rich in vitamin A, nutrients and antibodies needed by the new-born
- Give breast milk only for the first 6 months; it is all a baby needs to grow. Breast milk contains all the required nutrients for the baby in right proportions to grow normally in the first 6 months
- Breastfeed frequently on demand, ensure good latch on and positioning because it prevents sore nipples. Frequent breastfeeding promotes increased production of milk.
- Get help from a community health worker for any breastfeeding problems

b. Complimentary feeding

- Start introducing enriched foods to your child at 6 months in addition to breast milk. Complimentary food is necessary for growth and development of your child after six months. Balance diet containing carbohydrates, fat, proteins, vitamins and mineral promotes growth and development of the child
- Continue breastfeeding the baby on demand
- Give mashed soft food which a baby can swallow at different frequencies depending on age and breast-feeding status

Figure 3: Fatuma, Garowe District Hospital

- Give complementary foods three times a day, if a child is being breast-fed.
- Give a child food 5 times a day, if not breastfeeding.

c. Immunization

- Ensure the baby is fully immunized according to schedule
- Visit the health facility to get information on immunizations
- Vaccination is safe and necessary for your child.
- Full vaccination will save your child's life against diseases.
- Full vaccination will save your child's life against diseases.
- Full vaccination of your child within the first year of life can protect the child against the following childhood diseases: Diphtheria, Pertusis, Whooping cough, Tetanus, Hepatitis B, Poliomyelitis, Tuberculosis, Measles, BCG, haemolytic influenza and others

d. Diarrhoea management

- Give the child plenty of liquids during diarrhoea.
- Seek prompt treatment in a health facility if the child has not improved within 3 days or if the child is presenting with the following symptoms; vomiting, drinking with difficulty, fever, blood in stool or unable to breastfeed or dink anything
- If you are to give ORS at home ensure that you give half a cup for children under the age of 2 years and a full cup for children above the age of 2 years

e. Hand washing

- Wash hands with soap using running water at four critical points because it helps prevent diarrhoea
- Wash hands after visiting the toilet
- Wash hands after handling faeces

- Wash hands before preparing food and feeding the baby
- Wash hands before eating

f. Safe water

- Boil water for drinking
- Use chemicals like water guard, aqua tab, etc if they are available for treating water
- Store drinking in safe clean, covered and containers

g. Use of LLIN

- Sleep under an LLIN every night
- Recognise and seek early treatment for malaria
- Adhere to malaria treatment

h.Hygiene and sanitation

- Use of latrines by household members prevents diseases and contributions to improved health status of the community.
- Dispose faeces (including children's faeces) safely, and wash hands with soap and water after defecation before preparing meals and feeding children.
- Use latrines to reduce incidences of faecal-oral and waterborne diseases
- Defecation in the bush leads to transmission of diseases like. cholera, worm infections, dysentery
- Improved latrines keep away flies that can contaminate food with faecal matter

My story

'I have practiced exclusive breastfeeding with my children. It is possible to breastfeed for the first 6 months without mixing with 'fax'. When mothers come to the health facility I confidently advocate for exclusive breastfeeding for the first 6 months because I know it is possible' Fadhumo, a healthcare provider

3.3.5. Behaviour Change Communication Activities

I. Develop and produce messages and print materials advocating for desired changes in behaviour for each of the key practices among the target groups

II. Disseminate messages and print materials to the relevant target groups

III. Develop and produce an interactive radio program with call in questions and answers on MCH to educate mothers and communities on the desired behaviour as well as addressing key obstacles

IV. Conduct community level behaviour change activities aimed at promoting health and uptake of services for MCH. These activities include community meetings, Me and mother groups, household visits by community health workers, drama. These interpersonal activities are essential in dispelling rumours, misconceptions and addressing negative cultural and traditional beliefs on MCH issues.

V. Educate TBAs on promotion of MCH key desired practices so that they act as behaviour change agents to strengthen referral of mothers to health facilities.

VI. Establish mother support groups where mothers will learn from one another and peers on positive behaviours of MCH

VII. Conduct advocacy and sensitization meetings with religious leaders on MCH issues to solicit declaration and support ((Fatwa) for MCH and have a systematic engagement plan. It is important to work jointly with MOH, other ministries and stakeholders.

VIII. Training community health promoters (CHP) to mobilize communities and create demand and utilization for services. The CHP volunteers will be instrumental in the community based and interpersonal interventions

IX. Train CHP to work with TBAs and other volunteers to promote MCH key practices, trace defaulters and identifying ways of dealing with emerging barriers to accessing health.

X. Provide technical assistance to the CHP to plan and implement the community health promotion activities

XI. Organise exchange tours within the Country and in other countries to facilitate learning

4 STRATEGY TWO: ADVOCACY AND SOCIAL MOBILIZATION FOR MCH AMONG POLICY AND DECISION MAKERS.

4.1.1 Objectives of advocacy for policy and decision makers

Advocacy on MCH issues is targeted to the policy and decision makers to build political and social commitment, mobilize resources and development of supportive MCH policies in Puntland, Somalia. The strategy is designed to take a four pronged approach in advocacy related issues. These are:

a. Advocacy for the development of policies and guidelines

b. Advocacy for mobilization and coordination of MCH partners in the region

c. Advocacy for human and infrastructure capacity building for MCH

d. Advocacy for private public partnerships in MCH including media outreach

4.1.2 Target audiences for MCH policy makers and decision makers at the regional level

Table 7: Target audiences for MCH policy makers and decision makers at regional level

STAGE	AUDIENCES	SEGMENTS
1. Ante-Natal Care Delivery 2. And Intre-Partum Care 3. Post Natal 4. Child Health	Regional and National leaders	• Policy and decision makers at the MOH • International NGOs • Local NGOs • UN agencies • CHC (CBO)

Based on the KAPS assessment, the following current practices for policy and decision makers have been analysed and reflected in the subsequent sections.

- Low investment in health infrastructure
- Lack of supplies and products for MCH services
- Inadequate skills and knowledge among health workers to provide MCH services
- Lack of relevant MCH policies and guidelines
- Lack of MCH messages targeting all relevant audiences

- Lack of comprehensive capacity building plans for relevant target audiences on MCH
- Lack of PPP initiatives supporting MCH including MCH social marketing
- Absence of BCC collaboration initiatives with media

4.1.3 Communication Matrix for policy and decision makers at Regional level

Table 8: Communication matrix for policy and decision makers at regional level

Desired changes	Channel mix	Tools and materials
1. **Advocacy for Policies and guidelines on MCH and resource commitment** • Adequate fund support for MCH services • Increased investment in health infrastructure particularly for MCH • Increased number of policies developed that encourage uptake of MCH services by MOH	• Advocacy meetings • Presentation of re-search findings	• Fact sheets • Policy papers • Case study fact sheets • Letters and emails
1. **Coordination and mobilization of MCH partners** • Increased number of interventions with com-prehensive plans addressing MCH in coordi-nation with MOH and other key partners • Increased coordination among different partners in MCH particularly in BCC plan-ning, implementation and review as well as development of a comprehensive MNCH BCC M & E framework • Increased number of campaigns, messages and interventions on comprehensive MCH • Improved commitment by INGOs and MOH to provide supplies and products for MCH services	• Coordination meetings among partners • Advocacy meetings • Stakeholder meetings • Health sector meetings	• Fact sheets • Policy papers • Research papers • Case study fact sheets • Letters and emails

Desired changes	Channel mix	Tools and materials
2. **Capacity building of health workers on MCH particularly and BCC/health promotion** • Increased proportion of health workers trained in MCH and BCC • Increased proportion of Community health workers trained in BCC • Increased proportion of TBAs who understand key MCH practices and augment referral systems • Trained Community health promoters planning and implementing BCC for MCH at community level • Inclusion of a cadre of health promotion experts in the MOH sytem	• BCC MCH Training needs assessment • Develop BCC MCH training manuals for the different targets (Health workers, CHW/CHP, TBAs) • Develop comprehensive training plans • Conduct BCC training	• Training needs assessment tool • BCC training guide for health workers • BCC training guide for community health workers • BCC training guide for TBAs • Training guide for community health promoters
3. **Advocacy for Public Private Partnership initiatives and media outreach for MCH** • Increased number of Public Private Partnership initiatives on MCH • Increased MCH programs in the media	• Meetings with private sector to improve collaboration • Conduct focussed meetings to elicit commitment and action plans for MCH	• Presentations on MCH situation and areas of possible collaboration • Fact sheets • Case study fact sheets

4.1.4 Key advocacy and social mobilization messages

- Adopting conducive policies and decisions on MCH helps saves lives
- MOH/LINGOs/INGOS increased Investments on MCH saves lives of mothers and children
- MCH BCC capacity strengthening programs ensures sustainability of programs
- Public private partnerships including media outreach increases focus on MCH agenda, and attracts increased investment for sustainability
- Increased number of interventions with comprehensive plans addressing MCH in coordination with MOH and other key partners leads to success in country programs

4.1.5 Advocacy activities for policy and decision makers on MNCH

- Establish an intersectoral MCH coordination committee for improved coordination and oversight. Development of TORs is essential and establishment of a measurement criteria
- Establish an MCH partners mapping exercise for easier social mobilization through partnerships

- Develop messages and materials targeted for advocacy in different areas
- Conduct meetings with different MCH stakeholders and partners to deliberate on development of comprehensive plans addressing MCH in coordination with MOH
- Conduct advocacy meetings for increased investments in MCH funds, infrastructure, supplies
- Conduct meetings with different stakeholders to develop a health promotion capacity building plan and execution mechanism
- Establish public private partnerships whose agenda is addressing collaboration, investments in MCH and sustainability issues
- Conduct meetings with media agencies to advocate for partnerships in MCH social marketing.
- Train media agencies and journalists on comprehensive MCH issues for accurate and sufficient reporting. This will also increase reach and coverage of MCH issues if proper understanding is created.

5 ROLE OF STAKEHOLDERS IN IMPLEMENTATION OF THE BCC STRATEGY

The following stakeholders were identified as key in the implementation of BCC for MCH: MOH, other Ministries, LINGOs, INGOs, Donors, private sector and media, CBOs, Community, TBAs, Religious, traditional and political leaders. This section presents the roles of the various stakeholders

Table 9: Role of stakeholders in implementation of the BCC strategy

Stakeholders	Roles in BCC MCH strategy
Role Of MOH	• Develop health policy and strategy for MCH BCC • Planning, implementation, monitoring and evaluation of BCC • Capacity building for health workers on BCC • Coordination of MCH BCC work
Role of other Ministries	• Ministry of Education: inclusion of health education as a subject in the school's curriculum • Ministry of Information: Creating awareness and advocacy for MCH issues • Ministry of Women and Family affairs: creating awareness among the women and girls on MCH • Water agencies: contribute to water safety by taking measures to assure safety and quality. Assuring consistent supply to meet the needs of communities
Local NGOs	• Fundraising for BCCMCH Programs • Coordination with MOH to develop common plans for MCH BCC, implementation, monitoring and evaluation frameworks • Implementation of MCH BCC programs at all levels
International NGOs and UN agencies	• Support in MCH policy and guidelines development jointly with MOH • Support in provision of supplies and products for MCH services • Provide funding assistance to plan, execute and monitor MCH programs jointly with MOH • Provide technical assistance in the MCH and BCC programming • Provide technical assistance in MCH & BCC/Health promotion capacity strengthening programs jointly with MOH

Donors	• Provide funding support based on needs of the country priorities particularly as it regards MCH • Work jointly to develop comprehensive country plans in coordination with MOH, Health workers, LINGOs, INGOs • Provide a platform for joint Country plans, implementation and review including development of monitoring frameworks • Provide funding support jointly with MOH for MCH BCC capacity strengthening programs with clear needs assessments, comprehensive plans, resource /training materials • Develop a procurement, logistics and supplies plan in coordination with MOH and other stakeholders and institutions
Private Sector And Media	• Provide financial contribution to the MCH BCC programs as part of their social responsibility • Collaboration in fund raising for MCH BCC programs • Collaboration in MCH service provision • Collaboration in cost cutting mechanisms for MCH services
CBOs	• Planning, development, implementation, monitoring and evaluation of comprehensive MCH BCC awareness campaign plans at all levels including the community and facility based
Community/TBAs	• Communities need to be receptive and seek support in the adaption of healthy MCH attitudes and practices • TBAs to support referral system and adapt healthy MCH practices
Religious/Traditional Elders/Healers	• Provide information that is adapted positively to religious and traditional contexts to make them relevant • To be sensitised as MCH partners and change agents to mobilize their communities and promote healthy behaviours
Political Leaders	• Develop conducive law and regulations on MCH services • Commit resources for development of health facilities with emphasis on MCH as well as fund raising

6 MONITORING AND EVALUATION INDICATORS

The indicators outlined in this section are in line with the EPHS report defined standard interventions by Sub-programmes. Two sub-programmes are of importance to this strategy; these are core programme one on maternal, reproductive and neonatal health and core program two on child health. The indicators for these intervention areas have been aligned to the WHO recommended indicators on maternal, new born and child health.

Column one, on the Sub-programme and column two on the interventions have specifically been derived from the EPHS report. Column three which contains the relevant health communication indicators has been developed based on the interventions described in the BCC strategy ensuring that they are aligned to the overall EPHS strategy and WHO indicators. The following are some of the broad MNCH indicators;

- Maternal mortality ratio
- Under-five child mortality, with the proportion of new-born deaths
- Children under five who are stunted
- Proportion of demand for family planning satisfied (met need for contraception)
- Antenatal care coverage (at least four times during pregnancy)
- Antiretroviral (ARV) prophylaxis among HIV positive pregnant women to prevent HIV transmission and antiretroviral therapy for [pregnant] women who are treatment-eligible
- Skilled attendant at birth
- Postnatal care for mothers and babies within two days of birth
- Exclusive breastfeeding for six months (0–5 months)
- Three doses of combined diphtheria-tetanuspertussis (DTP3) immunization coverage (12–23 months)
- Antibiotic treatment for suspected pneumonia

Table one: Health communication indicators for maternal, reproductive and neonatal health

Table 10: Health communication indicators for maternal, reproductive and neonatal health

Sub -Program	Intervention	Indicator
Promotion of maternal health	• Promotion of appropriate nutrition for pregnant and lactating women, girls and adolescents • Antenatal – iron/folate supplements for 3 months, Vitamin A during first 6 weeks	• Proportion counselled on nutrition education • Proportion taking iron/folate supplements for the stated duration • Children under five who are stunted

Promotional of neo-natal nutrition	• Promotion of immediate and exclusive breastfeeding • Referral health centres/hospitals: nutritional care of premature babies and term babies without a mother	• Percentage of mothers practicing exclusive breastfeeding for six months (0–5 months) • Proportion of mothers breastfeeding within the first 30 minutes of delivery • Children under five who are stunted
Antenatal care	• Promotion of facility based delivery assisted by skilled attendants • Community health promoters and primary health workers encourage women to go to health facilities to deliver • Four (4) focussed antenatal visits (2 doses of TT, IPTp, ITN, Maternal nutrition, anaemia treatment, screening for pre-eclampsia, treatment for STI, Identification of high risk pregnancy, PMTCT, FP)	• Antenatal care coverage (at least four times during pregnancy) • -Proportion of demand for family planning satisfied (met need for contraception)
Care during delivery	• Skilled in facility attendance at birth with EmONC for all deliveries, including management of post-partum sepsis and haemorrhage, use of programmes and active management of third stage of labour • Essential new-born care –resuscitation, drying the baby, warmth, kangaroo care for premature babies	• Proportion of Skilled attendant at birth • -Maternal mortality ratio • -Proportion of mothers seeking postnatal care for mothers and babies within two days of birth
Care after birth	• Routine and post natal care for early identification and referral for illness as well as preventive • Early and exclusive breastfeeding for babies	• Proportion of mothers seeking post-natal care for mothers and babies within two days of birth • Percentage of mothers practicing exclusive breastfeeding for six months (0–5 months • Under-five child mortality, with the proportion of newborn deaths
Family planning	• Reproductive health education in schools • Promotion of avoidance of early marriage and early pregnancy	Proportion of demand for family planning satisfied (met need for contraception)

The table below describes the health communication Indicators related to core program two on Child Health.

Table two: health communication indicators for child health

Table 11: Health communication indicators for child issues

Sub-program	Intervention	Indicator
Control of diarrhoeal	• Rehydration with ORS • Referral for severe cases • Treatment with Zinc • Promotion of hand washing, safe disposal of faeces and safe water chain	• Proportion of households having hand washing facilities • Proportion of households using latrines / toilet • Proportion of households with water treatment methods • Proportion of children 0-59 months that had an episode of diarrhoea who received ORT.
Control of malaria	• Diagnosis and treatment of malaria • Fever management • ITN distribution	• Proportion of children properly using LLIN • Number of reported malaria cases among children • Proportion of pregnant women sleeping under LLITN
Vaccine preventable diseases	• EPI-routine, accelerated and 6 months vaccination campaigns for measles, polio, Vitamin A	• Proportion of children who are fully immunised by the first year
Promotion of young child nutrition	• Promotion of exclusive and immediate breastfeeding for 6 months • Promotion of complimentary child feeding and diversification of foods • Nutrition counselling	• Proportion of babies started on breastfeeding within the 1st 30 minutes after birth • Proportion of infants aged 0-6 months who are exclusively breastfed • Proportion of caretakers who have positive attitude towards colostrum. • Proportion of under five children with moderate and severe malnutrition.
Nutrition – micronutrient supplements	• Vitamin supplementation, every 6 months until 5 years • Iron/folate supplements for anaemia or multiple micronutrients	• Proportion of micronutrients rich food consumption and supplementation • Increase proportion of caretakers and communities with knowledge on importance of micronutrients • Proportion of children receiving Vitamin A supplementation every 6 months
Reduction of anaemia	• Malaria control and treatment • Deworming with 6 monthly campaigns • Iron and folate supplements at age specific doses • Referral of severe anaemia for blood transfusion	• Proportion of caregivers who seek prompt treatment for malaria • Proportion of children under five dewormed regularly

7 IMPLEMENTATION WORK PLAN

Strategy	Timeframe 2013-17
Behaviour change and communication	
Develop and produce messages and print materials advocating for desired changes in behaviour for each of the key practices among the target groups	Q1 2013
Disseminate messages and print materials to the relevant target groups	Q2 2013
Develop and produce an interactive radio program with call in questions and answers on MCH	Q3 2013
Conduct community level behaviour change activities aimed at promoting health and uptake of services for MCH. These activities include community meetings, Me and mother groups, household visits by community health workers, drama.	Q3 2013 – Q3 2017
Educate TBAs on promotion of MCH key desired practices so that they act as behaviour change agents to strengthen referral of mothers to health facilities.	Q4 2013 – Q4 2014
Establish mother support groups where mothers will learn from one another and peers on positive behaviours of MCH	Q4 2013 – Q4 2014
Conduct advocacy and sensitization meetings with religious leaders on MCH issues to solicit declaration and support ((Fatwa) for MCH and have a systematic engagement plan. It is important to work jointly with MOH, other ministries and stakeholders.	Q1 2014
Training community health promoters (CHP) to mobilize communities and create demand and utilization for services.	Q2 2014 – Q4 2014
Train CHP to work with TBAs and other volunteers to promote MCH key practices, trace defaulters and identifying ways of dealing with emerging barriers to accessing health.	Q2 2014 – Q4 2014
Provide technical assistance to the CHP to plan and implement the community health promotion activities	Q4 2014 – Q4 2017
Organise exchange tours within the Country and in other countries to facilitate learning	Q1 2013

Advocacy And Social Mobilization For MCH Among Policy And Decision Makers	
Establish an intersectoral MCH coordination committee for improved coordination and oversight	Q2 2013
Establish an MCH partners mapping exercise for easier social mobilization through partnerships	Q1 2013
Develop messages and materials targeted for advocacy in different areas	Q2 2013
Conduct meetings with different MCH stakeholders and partners to deliberate on development of comprehensive plans addressing MCH in coordination with MOH	Q3 2014 – Q4 2014
Conduct advocacy meetings for increased investments in MCH funds, infrastructure, supplies	Q3 2014 – Q4 2014
Conduct meetings with different stakeholders to develop a health promotion capacity building plan and execution mechanism	Q2 2014 – Q4 -2015
Establish public private partnerships whose agenda is addressing collaboration, investments in MCH and sustainability issues	Q2 2014 – Q4 -2015
Conduct meetings with media agencies to advocate for partnerships in MCH social marketing	Q4 2015 – Q42016
Train media agencies and journalists on comprehensive MCH issues for accurate and sufficient reporting.	Q4 2015
Monitoring And Evaluation	
Conduct a baseline MCH BCC assessment	Q1 2013
Development of a comprehensive M & E framework	Q3 2013
Develop reporting tools	Q3 2013
Conduct training on M & E for key personnel at all levels	Q1 2014
Conduct mid-term evaluation	Q3 2015
Conduct end term evaluation	Q3 2017
Total USD	

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