MODULE 3: Applying the Five-Step C4D Strategic Planning Process for Maternal, Newborn, and Child Health Promotion Programs

Module 3 provides a practical approach to developing a C4D strategic plan to address maternal, newborn, and child health issues across a continuum of care, based on the foundations for strategic C4D program design presented in Module 1 and Module 2 of this Guide.

In this Module, we (1) provide an overview of the key factors that contribute to maternal, newborn, and child mortality and morbidity, (2) discuss the MNCH continuum of care or lifecycle approach, (3) describe current strategies that work to prevent maternal, newborn, and child mortality and morbidity, and (4) walk you through the five steps of the C4D strategic planning process as it would apply to developing an integrated C4D strategy for reducing maternal, newborn, and child mortality and morbidity.

Key Factors Contributing to Maternal, Newborn and Child Mortality and Morbidity

Maternal Mortality and Morbidity

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. The major direct causes of maternal morbidity and mortality include hemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labor. The remainder are caused by or associated with diseases such as malaria, and HIV/AIDS during pregnancy.

Most maternal deaths are preventable using affordable health-care solutions to prevent or manage pregnancy, delivery, and postpartum complications, for example, administering magnesium sulfate for pre-eclampsia to lower the risk of developing eclampsia, or an injection of oxytocin to reduce the risk of hemorrhage after delivery.

Access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. It is particularly important that all deliveries are attended by a skilled health professional. Investing in health systems, for example, training midwives and making emergency obstetric care available and easily accessible is key to reducing maternal mortality. Addressing the barriers to use of care and creating an environment within households and communities that support women in seeking the needed care is also key.

Newborn Mortality and Morbidity[1]

[1] Newborn (or neonate) refers to an infant in the first 28 days after birth.

Maternal health and newborn health are closely linked. Almost 3 million newborn babies die every year.[2] At least three quarters of all newborn deaths occur in the first week of life.[3] The main causes of newborn or neonatal deaths are prematurity and low birth-weight, infections, birth asphyxia (suffocation) and birth trauma. These causes account for approximately 80% of deaths among newborns. Intervention strategies to reduce neonatal deaths include (1) skilled health worker attendance at delivery, and (2) home visits by a skilled health worker one to three days after birth, and again before the end of the first week of life, to promote:

- Exclusive breastfeeding
- Thermal protection
- Resuscitation
- Infection prevention (hygiene, cord care)
- Immunization
- Management of newborn illnesses
- Weighing newborns
- Skin-to-skin contact
- Identification of high-risk, low-weight babies

UNICEF and WHO developed an Action Plan for Healthy Newborn Infants 2014-2020 as a guidance for providing newborn infants with early essential and quality care during and immediately after birth.

Child Mortality and Morbidity

Pneumonia and diarrhoea[4] are the leading causes of death for more than two million children under age five (29 percent) worldwide. These diseases are related to poverty status and closely associated with malnutrition, poor sanitation in the home, and limited access to healthcare services. Stunted, underweight, and wasted children have an increased risk of death from diarrhoea, pneumonia, measles, and other infectious diseases.

Mortality and morbidity due to childhood pneumonia and diarrhoea are preventable through appropriate measures, including newborn care protocols, adequate nutrition, vaccinations, proper hygiene and sanitation, and access to safe drinking water (Key "Healthy Actions" for Preventing Pneumonia and Diarrhoea). These diseases can be treated with such cost-effective interventions as antibiotics for bacterial pneumonia and oral rehydration salts (ORS) for

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[2] UNICEF, WHO, The World Bank, United Nations Population Division, The Inter-Agency Group for Child Mortality (2013). *Levels and Trends in Child Mortality.* New York, NY: UNICEF.

[3] WHO (May 2012). *Newborns: reducing mortality: http://www.who.int/mediacentre/factsheets/fs333/en/ (accesses May 7, 2014).*

[4] Childhood pneumonia is a severe form of acute lower respiratory infection that specifically affects the lungs. Most acute respiratory infections result in mild illness (e.g., the common cold), but may lead to pneumonia in vulnerable children, especially when it coincides with diarrhoea and other illnesses. Childhood diarrhoea is the occurrence of loose or watery stools at least three times per day or more frequently than normal for any individual. In general, most episodes of childhood diarrhoea are mild, acute cases can lead to significant fluid loss and dehydration, which, if not treated in a timely manner, may lead to severe illness and even death. Diarrhoea is a common symptom of gastrointestinal infection, most commonly caused by bacteria, viruses and protozoa. Rotavirus is the leading cause of acute diarrhoea. Children with poor nutritional status and health are most susceptible to severe diarrhoea and dehydration than healthy children.

diarrhoea. Several approaches to deliver childhood pneumonia and diarrhoea prevention and control interventions have been shown to substantially improve the health of a child and his/her chances of survival, namely health facility-based care, Integrated Management of Childhood Illness (IMCI), and the education of mothers by frontline healthcare workers about the essential care of their babies, in household and community group settings UNICEF Pneumonia and Diarrhoea Action Plan).

A Continuum of Care or Lifecycle Approach to Maternal, Newborn and Child Health

The healthcare needs of mothers, newborns and children are intimately linked together. In the past, maternal and child programs addressed maternal and child health needs separately, resulting in gaps in care, especially for newborns. The World Health Organization states that:

> *"All women should have the highest attainable standard of health, through the best possible care before and during pregnancy, childbirth and postpartum period. This continuum of care encompasses the life-cycle of the woman, from adolescence through to the birth of her own child. Additionally, it includes all levels of the health system from the household to the first and a higher-level referral service site, as appropriate for the needs of each woman or newborn."*[5]

To reduce maternal and childhood mortality, a continuum of care needs to be provided throughout adolescence, pregnancy, childbirth, the postnatal and newborn period (addressing both mothers and infants), infancy, and childhood (Figure 1). Access to family planning services in adolescence can contribute to delayed pregnancy, and appropriate care during pregnancy can increase the chances of a safe birth. Skilled attendance at delivery and skilled care following the birth reduces the risk of mortality or morbidity for both the mother and baby.

Figure 1. Continuum of Care Throughout the Crucial Time Periods in the Lifecycle and Places of Care Giving.

[5] WHO (2006). Making Pregnancy Safer, Making a difference in countries: Strategic approach to improving maternal and newborn survival and health. Geneva: WHO.

Source: Adapted from de Graft-Johnson et al. (2006). Opportunities for Africa's newborns: Practice, data, policy and programmatic support for newborn care in Africa. Geneva: The Partnership for Maternal, Newborn & Child Health.

Maternal, newborn, and child healthcare are usually part of a package of essential reproductive and child health interventions. Healthcare interventions that link family planning, and maternal, newborn and child health and integrate service delivery contribute to fewer deaths and disability related to childbearing. Linking interventions in packages can reduce costs, facilitate greater efficiency in training, monitoring and supervision, and strengthen supply systems. Such services have been developed by the World Health Organization (WHO) in collaboration with the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank and the Partnership on Maternal, Newborn and Child Health.

The place of care giving is an important dimension of the continuum of care (Figure 1). In many developing countries, maternal, newborn, and child deaths occur at home largely due to the parents' delaying or not seeking healthcare for their child. These delays are often the result of a lack of knowledge about danger signs and the importance of seeking care. An effective continuum of care supports linkages between home healthcare, a local level healthcare facility, and a hospital. Strategies for strengthening these linkages include improving the skills of healthcare workers and promoting behavior and social change at the individual, household and community levels.

Current Strategies for Preventing Maternal, Newborn and Child Mortality and Morbidity

Poor maternal, newborn, and child health and mortality/morbidity can be attributed, in large part, to modifiable individual-level factors, including a lack of knowledge about essential care practices, poor attitudes toward healthcare services or service providers, and traditional or normative behaviors that perpetuate detrimental health practices. Communication strategies to increase knowledge, and to change attitudes, behaviors, and norms at the individual, community, and societal levels are essential to decreasing the risk and incidence of, and mortality and morbidity of mothers, newborns, and children under the age of five. Communication, and more specifically Communication for Development (C4D), is a cross-cutting strategic approach that should be applied by multiple sectors or programs, for example, Health, Nutrition, HIV/AIDS, Social Protection, and Water, Sanitation and Hygiene (WASH), to create demand for, and utilization of, quality health services, and to adopt positive, healthy, protective behaviors among individuals, families, and communities.

The Evidence Summit on Population-Level Behavior Change for Child Survival and Development held in June 2013, led by USAID and supported by UNICEF summarized a systematic evidence review process for effective MNCH life-saving practices. Evidence Review Teams (ERTs) reviewed literature in six key areas: (1) Supporting Children and Caregivers, (2) Empowering Communities, (3) Sustainable Systems and Policy Supports, (4) Gender Dynamics, (5) Stigma and

Discrimination, and (6) Advances in Science, Technology, and Innovation.[6] The key findings for promising evidence-based interventions are summarized in Table 1.

Table 1. Summit Findings for Promising Evidence-Based MNCH Interventions.

Areas of Review	Summary of Key Evidence
Supporting Children and Caregivers	• Direct behavior change efforts conveyed one-on-one by trained workers through home visiting programs or other types of community settings over a long time period with multiple components of health and development can yield positive outcomes • Direct demonstrations of complex behaviors (e.g., correct mosquito-net hanging, ORS mixing, and hand washing) yield positive results
Empowering Communities	• Community mobilization interventions that maximize community collaboration and participation can have a beneficial impact on child health indicators • Norms, level of cohesion and self-efficacy that communities foster around new knowledge is most critical for behavioral transformations • Participatory approaches can improve dialogue and decision-making aimed at removing barriers to basic services
Sustainable Systems and Policy Supports	• Trained local health workers should be included in outreach and delivery programs, coupled with education, support, monitoring, and direct connections to health professionals • Introduction of conditional cash transfers is effective in promoting behaviors that improve the nutrition and development of young children • Effective programs include interpersonal counseling by health care personnel, social networks influencers, involvement of community leaders and multiple levels of community stakeholders, promoting both individual and collective behaviors, and fostering supportive social norms • Including men in educational interventions to expand the scope of behavior change interventions to address social and structural factors, such as gender norms and inequalities, can be beneficial to effective program intervention
Gender Dynamics	• Interventions empowering women to take actions to address health issues and those that empower adolescents and their families to change community norms around child marriage can be beneficial in addressing social and structural factors such as gender norms and inequalities • Gender-oriented interventions that raise issues of gender norms and rights, and seek to give women access to resources to improve health behaviors and health outcomes can lead to delays in age at marriage, increased use of family planning, reduced child stunting, and reduced maternal and child mortality
Stigma and Discrimination	• Although promising practices related to stigma were limited, there is a general consensus that interventions should target multiple socio-ecological levels to and address social norms and structures influencing individual attitudes and behaviors
Advances in Science, Technology, and Innovation	• mHealth interventions have been effective in improving adherencence to medications, uptake of services, caregiver learning, and clinical provider compliance with protocols • Investments in mHealth can effectively improve child health by connecting caregivers to the health system, improving quality of services provided by health workers, and facilitating adherence to recommended treatments.

[6] Population-Level Behavior Change Evidence Summit Highlights:
https://www.youtube.com/watch?v=XymhTuylxMg&feature=youtu.be

- Transmedia or multi-platform storytelling and social media interventions may improve cognitive, social and emotional development in children, and provide effective support to health education interventions in maternal and child health

Relatively simple and low-cost interventions that reduce maternal, newborn, and childhood mortality and morbidity and improve child survival are available for individuals, families, communities, and policymakers (Figure 2). To read a compendium of case studies about innovative approaches to MNCH, click here.

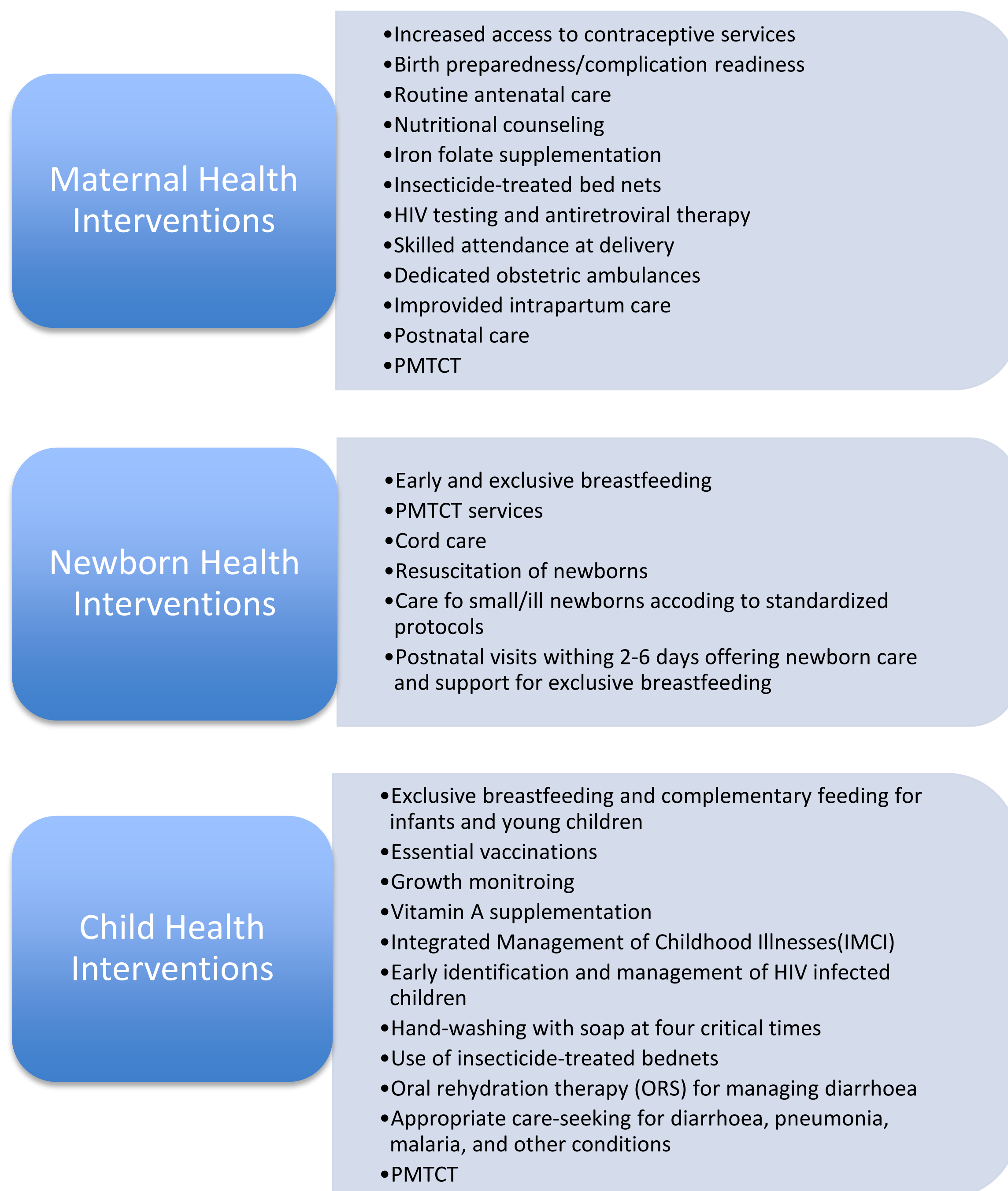


Figure 2. Low-Cost Interventions to Reduce Mortality and Morbidity Among Mothers, Newborns, and Children.

To re-cap from Module 1, Communication for Development (C4D) is a systematic, planned, and evidence-based approach to promote positive and measurable behavioral and social change. C4D is both a strategy and an approach to engage communities and decision-makers at local, national, and regional levels, in dialogue toward promoting, developing, and implementing policies and programs that enhance the quality of life for all. Communication strategies to increase knowledge, and to change attitudes, behaviors, and norms at the individual,

community, and societal levels are essential to decreasing the risk and incidence of illnesses, and morbidity and mortality, among mothers, newborns and children. Development efforts of the past decade focused on individual- and household- level behavior change in specific populations, using strategies that produced small-scale, fragmented, short-term behavior changes. The emphasis of child survival development programs was on supplying information about wellness and life-saving practices (e.g., exclusive breastfeeding, resuscitation, care-seeking), biomedical interventions (e.g., vaccines, antibiotics), treatments (e.g., ORS, zinc supplements, water purification solutions), and/or technological innovations (e.g., VIP latrines), without much attention to creating demand for the interventions using evidence-based communication strategies (Literature Review of C4D Strategies for Newborn Care and Child Survival).

Achieving the goals for decreasing morbidity and mortality from maternal, newborn, and childhood conditions requires communication inputs to raise awareness, increase knowledge, encourage positive attitudes and healthy practices about maternal, newborn, and child illness prevention and control, and to motivate individuals, families, communities, social systems to adopt the interventions and create norms around the healthy maternal and child survival behaviors. Current evidence-based communication strategies used to promote positive individual, family, community, and social system practices in order to prevent maternal, newborn, and child mortality and morbidity are summarized in Table 2:[7]

Table 2. C4D-Related Evidence-Based Strategies to Prevent Maternal, Newborn, and Child Mortality and Morbidity.

Interpersonal or Group Strategies	Community-Based Strategies	Strategic Communication Strategies
• Home visits • Community Health Workers (CHWs)/Lay Health Workers (LHWs)/Frontline workers/Health agents • Counseling/Peer counseling • Faith-based mobilization • Support groups • Social networks • Mobile clinic • School-based	• Community mobilization • Community engagement • Community outreach • Community intervention • Social mobilization • Empowerment	• Advocacy (policy, media, agenda-setting) • Mass- or multi- media • Social media • Social marketing • Positive deviance

[7] For a more detailed description of the evidence, see Shefner-Rogers, C. (2013). *Applied communication for development strategies for newborn care and the prevention and control of childhood pneumonia and diarrhoea: A literature review of the evidence of impact on child survival*. Albuquerque, NM: Summary report commissioned by UNICEF/NYHQ (Literature Review Report).

Consider a Sector-Wide Approach

Interventions that are integrated with multiple sectors will have more impact on social and behavior change through reinforcing mechanisms (Systematic Review of Integration of MNCH). For example, in Kenya, a mother arrived at a clinic with her sick baby who had a high fever. The mother received a malaria medication and insecticide-treated bed net and returned home. The baby, however, was not weighed so the mother was not aware that her child's growth was faltering and required a diet supplemented with nutritious weaning foods. The mother was not offered an HIV test to determine her status and the possible necessity of treatment and recommendations for family planning; her child was not tested for HIV or given required immunizations. While the child received immediate treatment for malaria symptoms, there were multiple underlying health needs that were undetected and unmet as a result of a lack of integration. To address this lack of integration, the government of Kenya introduced policy to support integrated MNCH service delivery throughout the country in public, private, and faith-based facilities. [8] For a useful guide on integrating MNCH and PMTCT click here.

The UNICEF Strategic Plan 2014-2017 outlines key sectors that converge to support the rights of all children, especially the most vulnerable and excluded, and address the needs of their families and communities. Table 3 provides a list of key approaches or activities for integrating C4D across UNICEF sectors.

Table 3. Key Approaches for Integrating C4D Across UNICEF Sectors.

Sector	Approaches and Activities
Health	▪ Equitable delivery of interventions ▪ Increasing access to lifesaving and preventive interventions, including humanitarian action ▪ Improving caregiver knowledge of high-impact interventions ▪ Mobilizing partners and communities to create an enabling environment and policy development/change ▪ Strengthening health systems, including the contributing, as appropriate, to universal health coverage ▪ Improving the quality and use of data for making decisions ▪ Ensuring integration of health services provided to mothers, newborns and children
HIV and AIDS	▪ Promoting comprehensive sexuality education ▪ Protecting the rights of excluded adolescent populations who are highly affected by HIV ▪ Working with partners across sectors, to address the root causes of vulnerability to HIV and to promote healthy behaviors
Water, Sanitation and Hygiene (WASH)	▪ Capacity development to increase sustainable access to safe drinking water ▪ Eliminate open defecation and improve access to adequate sanitation ▪ Increase hand-washing and good hygiene practices ▪ Provide safe drinking water, sanitation and hand-washing facilities in schools and health centres (with attention to the needs of girls)

[8] Adapted from Scholl, E (2010). Integrating family planning, HIV, and MNCH Services in Ethiopia and Kenay: http://blog.usaid.gov/2010/12/integrating-family-planning-hiv-and-mnch-services-in-ethiopia-and-kenya/ (accessed May 22, 2014).

	▪ Increase preparedness to respond to humanitarian situations
Nutrition	▪ Supporting delivery of vitamin and micronutrient supplementation and iodized salt ▪ Promoting exclusive breastfeeding ▪ Community-based prevention and management of malnutrition ▪ Supporting disadvantaged and excluded families to apply good nutrition and care practices and seek comprehensive nutrition services ▪ Expanding focus on early childhood given the crucial impact of nutrition on brain development and function during the first 1,000 days ▪ Scaling-up and integrating the management of severe acute malnutrition ▪ Increasing country capacity to ensure protection of the nutritional status of children in humanitarian situations
Social Inclusion	▪ Understanding the patterns and drivers of exclusion and disadvantage, including the impact of gender inequality ▪ Supporting countries to design legislation and policies that promote social inclusion, support interventions on rule of law and access to justice that address discrimination and promote accountability ▪ Strengthening families in their child-care role, particularly for the youngest children, and supporting the poorest and most marginalized families to demand and access basic health services ▪ Emphasizing the meaningful participation of children, including adolescents, in processes that relate to them, including through strengthening their own decision-making and communication capacities

In the final section of this Module, we present the five steps for developing a strategic C4D plan to prevent maternal, newborn, and child mortality and morbidity with relevant guidelines and examples.

The Five Steps for Planning Strategic C4D Programs to Prevent Maternal, Newborn and Child Mortality and Morbidity

In Module 2 of this Guide, we presented a five-step process for developing a C4D strategy for health behavior and social change programs (Figure 3). Following are the five steps with examples relevant to maternal, newborn, and child health promotion and mortality prevention programs.

Figure 3. The Five Steps of the Strategic C4D Planning Model.

Step 1: Data Collection and Analysis

The data collection and analysis step requires you to (1) understand the problems of maternal, newborn, and child mortality and morbidity at the individual, family, community, and social levels of the social system in which you are working, (2) identify the challenges or bottlenecks and facilitating factors that will enable you to implement your C4D interventions, and (3) determine the priorities for your C4D program based on your findings.

What Information Should You Collect and How Should You Collect It?

The Data Collection and Analysis Checklist presented in Module 2 of this guide provides you with a list of the type of information that you will need for your situation analysis. You should consider each question for the five levels of the social ecological model (individual, interpersonal, community, organizational, policy/societal).

Table 3 provides you with a list of (1) the types of questions you should ask for identifying the problem, the populations/population segments, the existing programs and policies, the communication capacities, and the partnerships that will provide you with a comprehensive view of the problem of maternal, newborn, and child mortality and morbidity, and (2) some of the possible primary and secondary sources for this information.

Wherever possible, obtain disaggregated data (i.e., stratified by age, parity, residence, and socioeconomic characteristics like education level, ethnicity, and wealth quintile) so that you are able to identify population sub-groups that are at highest risk of mortality and morbidity.

To organize your data collection and analysis, you can follow the Steps in Making a Formative Research Plan.

Once you have collected the necessary and relevant information and data, you are ready to analyze the data and set priorities for which populations you will reach and which interventions will be most effective. The next step is to develop your C4D program strategy.

Table 3. Types of Questions and Sources of Information for Conducting a Situation Analysis.

QUESTIONS	SOURCES OF INFORMATION*

The Problem
• Where and why are mothers, newborns, and children under the age of 5 years dying?
• What are the rates and ratios of mortality and morbidity? Key maternal and child health indicators should include (but are not limited to):
  o Mortality and morbidity data (e.g., 350/100,000 live births)
  o Proportion of women with at least one antenatal care visit
  o Skilled birth attendance rate
  o Contraceptive prevalence rate
  o Infant mortality rate
  o Under 5 mortality rate
  o Low birth weight
  o Prevalence of iron deficiency anemia in pregnant women
• What are the key risk factors associated with maternal, newborn, and child mortality and morbidity among your population of interest?
• What practices at the individual/household level are or are not being conducted to keep mothers, newborns and children from dying or getting sick? For example:
  o Are mothers accessing antenatal care?
  o Are mothers practicing exclusive breastfeeding?
  o Do mothers provide bed nets for their newborn/child to prevent malaria?
  o Where do families take their newborn when the infant is sick?
  o Do mothers continue to breastfeed when their child has diarrhoea?
• What practices at the community level are or are not being conducted to keep mothers, newborns and children from dying or getting sick?
• What practices at the policy level are or are not being conducted to keep mothers, newborns and children from dying or getting sick?
• What is the health context (e.g., literacy rate, poverty, geography/topography)
	Secondary Sources:
	• Multiple Indicator Cluster Survey (MICS)
	• Demographic and Health Survey (DHS)
	• UNICEF global databases on key indicators: http://www.childinfo.org/ ;
	• Government statistics/reports (e.g., census data, registration and vital statistics data, health services records)
	• Donor reports
	
	Primary Sources:
	• Household/community survey
	• Focus group discussion
	• In-depth interviews
	• Social mapping
	• Social network survey
	• SWOT analysis
	• Direct observation

- What does the continuum of care look like for your population of interest? What healthcare components are available (e.g., family planning; antenatal care; delivery care by a skilled provider; obstetric emergency services; newborn care; postpartum care; diagnosis or management of HIV/AIDS including PMTCT and STIs; prevention and management of childhood illnesses; malaria prevention; prevention and management of essential vaccinations; home visits; nutrition; WASH)
- Are there important health care gaps, such as the lack of an effective postnatal care package?
- To what degree is there coordination of care?
- What is the coverage of life-saving MNCH services at central, district, and village levels?
- What is the human resources availability?
- What is the quality of care?
- How accessible are the healthcare components to your population of interest?
- Is there integration of MNCH interventions for your population of interest?
- Is there a systematic approach to supporting families to practice healthy home behaviors such as breastfeeding, good hygiene, and early care seeking for illness?
- Are there barriers to care, for example cultural barriers, or a lack of key staff or supplies, or high costs during childbirth?
- Monitoring and evaluation capacity
- Partnerships and coordination
- What are the key challenges to addressing the problems at each level of the social ecological model?
- What are the specific desired behaviors/practices that will address the problems?
- Are there communication channels in place that can be used to address the population and problems?
- What resources are available for addressing the problem (budget)?

The Population of Interest/Participant Groups	**Secondary Sources:**

• Which group is most DIRECTLY AFFECTED by maternal, newborn, and child mortality (e.g., women of reproductive age, men of reproductive age, adolescents and youth, poorest, hard-to-reach)? • Who DIRECTLY INFLUENCES people who are directly affected by maternal, newborn, and child mortality (e.g., faith based leaders/networks, traditional networks, women and men's organizations, workplaces, community and opinion leaders, political leaders, private sector leaders, service providers at health facilities, pharmacists, community health workers, volunteers)? • Who INDIRECTLY INFLUENCES people who are directly affected by maternal, newborn, and child mortality (e.g., ministries and policymakers, education, agriculture, gender and children's services, culture and social services)? • How should we segment our population(s) of interest and use our resources to address the primary and secondary populations? • What is the current level of knowledge, attitudes, perceptions (susceptibility, severity, safety of prevention/treatment methods), and practices (including traditional) for each participant group? • What is the readiness to change? • What misinformation or rumors exist among your population of interest? • What are the challenges that people face in trying to implement the desired behaviors? (Prioritize those challenges.) • What do the participant groups want to know about how to prevent maternal, newborn, and child deaths? • Where or from whom do the participant groups get their information about the problem or similar health issues? • Who are the opinion leaders in each of the participant groups with regard to the problem? • What communication strategies/channels will be most efficient/effective in reaching the participant group to change KAP, self/collective efficacy, the enabling environment, etc.? • What are the social and media habits of the intended participants groups?	• Multiple Indicator Cluster Survey (MICS) • Demographic and Health Survey (DHS) • UNICEF global databases on key indicators: http://www.childinfo.org/ ; • Government statistics/reports (e.g., census data, registration and vital statistics data, health services records) • Donor reports **Primary Sources:** • Household/community survey • Focus group discussion • In-depth interviews • Social mapping • Social network survey • SWOT analysis • Direct observation

• How will the participant groups be involved in developing the interventions to address the problem?	
Existing Programs and Policies • What current or recent programs exist that address the problem with your intended participant groups? • What are the current policies related to the problem?	**Secondary Sources:** • Policy briefings/reports • Government reports • Donor reports **Primary Sources:** • Inventory of organizations/programs working in same or related areas
Communication Capacities • What are the available communication channels that are accessible to the intended participant group? • What are the capacities of the (local) media to generate information about the problem and about prevention and treatment for the problem? • What traditional media are relevant for the intended participant group? • What are the capacities for developing print and other materials? • What are the capacities for interpersonal communication and counseling? • What are the existing social networks?	**Secondary Sources:** • Country reports on communication capacity **Primary Sources:** • Inventory of communication/media outlets with capacity to work in MNCH and/or related areas
Partnerships • Who are the potential partners for the program (don't forget about private partners and media partners)? • What are the key roles for each of the partners? • How will partners communicate about program activities/issues?	**Secondary Sources:** • Country or government reports • Donor reports **Primary Sources:** • Inventory of partner organizations

* Secondary sources are documents/reports that were written/published by someone other than yourself and an individual/organization that you hired to collect the data and write the report. Primary data sources are data/information collected by you or an organization that you hired to collect the data and write a report.

STEP 2: STRATEGIC DESIGN

The first step in the strategic design phase is to establish the program goal so that all stakeholders are aiming toward the same end-point for your C4D program.

An example of a program goal is: To accelerate the reduction in maternal, newborn, and childhood mortality and morbidity in line with MDG4 and MDG5.

Establish SMART Communication Objectives

Your C4D program objectives are based on the evidence you collected and analyzed in Step 1 (above). You should be able to translate the information, including the most-at-risk populations, desired changes, perceived barriers, and perceived benefits to your intended population group(s) into SMART objectives.

Establishing SMART objectives requires that you identify (1) the specific audience, group or population whose behavior your are aiming to change, (2) the intended behavior, (3) the place and timeframe for change, and (4) the degree or criteria of success:

1. A = Audience (the group or population whose behavior you are aiming to change)
2. B = Behavior (the intended performance outcome)
3. C = Conditions (the place and timeframe for change)
4. D = Degree or criteria of success (how much change you expect to see within a specific timeframe)

An example of a clearly stated SMART MNCH objective is:

> To increase by 20 percent the number of Kenyan women of reproductive age who understand the importance of completing at least four antenatal visits during their pregnancy, by December 2016.
>
> A = Kenyan women of reproductive age
> B = Understand the importance of completing at least four antenatal visits during their pregnancy
> C = Kenya, by December 2016
> D = Increase by 20 percent

Table 4 provides an example of the information that led to SMART C4D objectives:

Table 4. Examples of How Desired Changes, Perceived Barriers and Perceived Benefits Feed Forward Into SMART C4D Objectives.

Population: Women of Reproductive Age			
Desired Changes	**Perceived Barriers**	**Perceived Benefits**	**SMART C4D Objectives**
• Increased utilization of ANC and skilled attendance at delivery • Increase in prompt healthcare for complications of delivery (emergency obstetric care and services) • Increased practice of exclusive breastfeeding for at least six months after delivery	• Lack of knowledge about when ANC visits should begin and how many are necessary • Lack of confidence about benefits of skilled attendants during delivery • Lack of knowledge regarding postpartum care and warning signs • Long distance to a health facility and lack of transport • Cost of giving birth in a facility • Health provider attitudes Lack of confidence about the benefits of breastfeeding and how long it should be continued • Religious and traditional beliefs • Lack of male involvement in decision-making on RH issues	• Improves health of mothers and their children • Reduces major causes of maternal deaths, for example, obstructed labor, high blood pressure, and infections	• Increase by X% the number of women who feel confident that seeking a minimum of four ANC visits during pregnancy will improve their health and the health of their babies by (date) • Increase by X% the number of women who seek ANC as soon as they know they are pregnant by (date) • Increase by X% the number of women who plan to deliver their babies at a health facility and have a transportation plan by (date) • Increase by X% the number of women who think the benefits of ANC and delivering at a health facility outweigh the costs by (date) • Increase by X% the number of women who report positive provider-client interaction on RH by (date) • Increase by X% the number of women who know warning

			signs after delivery and when to seek the help of a health provider by (date) • Increase by X% the number of women who feel confident that breastfeeding exclusively for six months will improve the health of their babies by (date) • Increase by X% the number of women who speak to their partners about preventive childcare practices issues by (date)
Population: Community Leaders			
Desired Changes	**Perceived Barriers**	**Perceived Benefits**	**SMART C4D Objectives**
• Increase in quality and accessibility of reproductive health services within the community • Increased integration of reproductive health information and services into other related programs	• Lack of confidence about the benefits of reproductive health services for communities • Religious and traditional beliefs • Competing issues and resources	• Improved economic growth with more healthy young people who are able to join the workforce	• Increase by X% the number of community leaders who believe that reproductive health service programs help their communities to improve their quality of life and the health of families and individuals by (date) • Increase by X% the number of community leaders who understand the components of effective reproductive health service programs and how to support them in their communities by (date)

	• Increase by X% the number of community leaders who believe that their fellow community leaders support reproductive health service for the community by (date) • Increase by X% the number of community leaders who become advocates for reproductive health service program provision by (date)

Develop Program Approaches

C4D interventions should address desired changes and SMART objectives. The situation analysis information about who is directly affected by maternal, newborn, and child mortality and morbidity, who are the influencers, and where and from whom individuals and groups would like receive information about maternal, newborn, and child health should guide your selection of the approach(es) you will use for your interventions. The resources available (human and material) will also help to determine which approaches to use in order to achieve the maximum impact with the greatest efficiencies.

Examples of approaches include:

- Addressing inequity and social determinants of health through advocacy/policy change in the most underserved, under-resourced districts
- Implementing multi-media campaigns to promote positive social norms around childbirth and childcare
- Community outreach to promote skilled attendance at delivery
- Providing community- or school-based entertainment-education sessions about health through the lifecycle for adolescents
- Mobilizing communities for child immunization days
- Developing a framework for MNCH services at the district or community level
- Strengthening the capacity of healthcare providers to deliver quality postpartum care through training
- Strengthening systems for monitoring and evaluation of MNCH interventions and outcomes through training

You may consider using a phased approach, that is, to roll out your interventions by population group, by geographical location, by message, or some other relevant factor. For example, the first phase of a C4D program intervention to increase antenatal care visits might be designed to first reach pregnant women with messages that promote visits to a health facility for antenatal care. The second phase might address obstacles and barriers to seeking antenatal care by promoting quality care by providers at healthcare facilities. A third phase might involve engaging community leaders to advocate for quality antenatal care in the community facility(ies).

Such strategies as social mobilization, advocacy, and behavior change communication should be considered to reach and engage your population(s) of interest with your messages.

Determine the Appropriate Channels to Use For Your Population

Most often, focus group discussions and interviews are used to determine where and from whom your population of interest would most like to receive information about a particular topic. Once you know this information from your key population(s), you can develop a channel mix (Table 5). The availability of communication channels and coverage for your area, literacy levels, and material and human resources will also contribute to determining the appropriate channels you will use.

It is useful and often more effective to use multiple channels to reach your population group. Messages delivered through multiple channels will have an additive and reinforcing affect on your listeners/viewers/participants.

Table 5. Examples of Population Groups and Matched Communication Channels.

Population Group	Channel
Pregnant Women	Women's support groups; posters; radio
Husbands	Billboards; presentations at worksites; tea stall sessions in markets; magazine advertising; text messages
Community Leaders	Leaflets; text messages; billboards; religious ceremonies

Develop an Implementation Plan

Once the strategic design elements (e.g., goal, objectives, approaches, communication channels, and activities) are decided, they should be spelled out in a concise strategic design document that includes an implementation plan. The implementation plan should include:

- Approaches/Strategies
- A schedule of activities with benchmarks to monitor progress
- Process indicators
- A description of the management tasks for the program, including partners' roles and responsibilities and timelines
- A line-item budget

An example of an implementation plan is the Implementation Plan for Tanzania MNCH 2008-2015.

Develop a Monitoring and Evaluation Plan

Monitoring and evaluation should be planned as soon as you have identified the objectives for your C4D program Step 4 - Monitoring Plan Checklist. The indicators for measuring the progress and success of your program are tied to the objectives that you developed in this step of the process. Before you move to Step 3, you should develop indicators and identify data sources for monitoring the implementation of your program (process indicators) and for recording reactions to the messages and feedback from your intended populations. You should decide on the study design you will use to measure process outcomes and changes in your intended populations.

Step 3: Development and Testing of Messages and Materials

Step 3 requires translating the situation analysis (Step 1) and strategic plan (Step 2) into the communication interventions/activities, including messages and materials that will be used to reach and engage your intended populations. The interventions/activities and messages should relate to each of your program objectives and should be created with participation from key stakeholders, including partners, community workers, media experts and others.

Message and Materials Development

A first step in the message development process is to create a Message Brief, i.e. a document that outlines the intent of the messages for specific populations. Module 2 provided you with details regarding message and materials development. Here we provide examples of key MNCH messages that can be adapted (e.g., language, tone, type of appeal, and sensitivity) for your population(s) of interest (Table 6).

Pretesting your messages is key to ensuring that the words will be effective toward motivating actions. You can pretest through focus group discussions where you present key messages, and/or materials containing messages, for appeal, relevance, comprehension, acceptability, persuasion, and recall (see Module 2, p.17 for details).

Ensure that you do not overload your intended population with too many messages; three to five messages are enough for one population group in a brief timespan (e.g., 3 months).

It is important to acknowledge that not all messages will be received by your population(s) as intended. For that reason, it is important to develop a Crisis Management Plan.

Table 6. Examples of Key Messages for Various Intended Populations Along the Continuum of Care.

Population Group	MNCH Continuum of Care				
	Pre-Pregnancy	**Pregnancy**	**Birth/Delivery**	**Postnatal (Mother and Newborn)**	**Infancy/Childhood**
Adolescents	• Delay marriage • Delay first birth • Prevent unwanted pregnancy by accessing contraceptive counseling and family planning services				
Women	• Prevent unwanted pregnancy by accessing contraceptive counseling and family planning services	• Seek antenatal care as soon as you learn you are pregnant • Make at least 4 antenatal care visits during your pregnancy • Use insecticide-treated bed nets to prevent malaria • Every pregnancy faces risks, know the danger signs	• Ensure skilled attendance at delivery • Wash your hands before handling the baby • Breastfeed your baby 30 minutes after delivery	• Keep the baby warm after delivery • Breastfeed your baby exclusively for six months • Know the danger signs for newborns • Seek immediate care for newborn danger signs	• Continue breastfeeding and introduce complimentary feeding • Know the danger signs of diarrhoea and pneumonia • Seek immediate attention for diarrhoea and pneumonia

		• Seek immediate care for danger signs • Plan to deliver you baby at a health facility • If you deliver at home, plan for a skilled attendant to be present			
Men	• Discuss family planning, including the number and spacing of children	• Know the elements of birth preparedness and complication readiness (BPCR)	• Ensure skilled attendance at delivery • Wash your hands before handling the baby • Breastfeed your baby 30 minutes after delivery • Know the danger signs for newborns • Seek care for newborn danger signs	• Know the danger signs for newborns • Seek immediate care for newborn danger signs • Support your partner in exclusive breastfeeding	• Support your partner in excusive breastfeeding and complimentary feeding • Know the danger signs of diarrhoea and pneumonia • Seek immediate attention for diarrhoea and pneumonia
Family Members	• Support the couple's decision about when and how many children they will have	• Know the elements of birth preparedness and complication readiness (BPCR)	• Support mother/couple to deliver with a skilled attendant	• Support timely essential immunizations for children	• Support timely essential immunizations for children

Healthcare Providers	• Motivate women and men to utilize family planning	• Know how to provide quality antenatal care	• Know how to provide essential newborn care practices • Know the danger signs in newborns • Know how to assess danger signs in newborns and start treatment	• Know how to provide quality postnatal care (e.g., warming, resuscitation, postnatal visits 2-6 days after delivery) • Promote early and exclusive breastfeeding • Know the danger signs for newborns and how to treat them or when to refer to another level of care	• Promote exclusive breastfeeding • Know how to provide growth monitoring, vitamin A supplementation, etc. • Motivate women/families to immunize their children • Know how to recognize danger signs of diarrhoea, pneumonia, malaria and other conditions, and refer to a higher level of care as necessary • Provide early identification and management of HIV infected children
Community Leaders	• proved health infrastructure	• Community surveillance of	•	• Support timely essential	• Support timely essential

	(e.g., good roads, transportation, water and sanitation services) in the community leads to saving mothers and children	pregnant women helps to save mothers and children • Provide the resources to support BPCR		immunizations for children	immunizations for children
Policymakers	• Maternal, newborn, and child health are human rights • Maternal, newborn, and child health are vital economic and social investments • Provide human and material resources to support maternal, newborn, and child health promotion and services • Ensure the availability and accessibility of essential commodities (e.g., vaccines) at the central, district, and village levels				
Religious Leaders	• Discussing MNCH with your religious groups leads to saving mothers and children • Support timely essential immunizations for children				

Step 4: Implementation and Monitoring

The quality of program management/supervision, and of data, frequency of data collection and the use of data for decision making are critical for the implementation of efficient and effective MNCH programs.

Produce Materials and Develop a Dissemination Plan

Once you have finalized the program messages and materials, interventions and activities (Step 3), you should determine when and how, and/or how often materials and activities will be produced and disseminated or implemented. If you intended to conduct community meetings, advocacy events, or other participatory or interactive activities, you will need to plan for, and develop a schedule for, each event/activity. Your dissemination plan should include a description of the distribution channels or event locations (including dates and times), a promotion plan, the identification of who is responsible for ensuring that the materials are disseminated, and a plan for how you will monitor the distribution or placement of materials. Communicate this plan will all partners and stakeholders.

Make a plan to train individuals or groups that require skills-building support to manage and implement the program, including program managers, staff, and field workers/community health workers. For example, if you are promoting the services of local health clinics to treat childhood pneumonia, it is essential that clinic staff is properly trained to address the child's illness and the parents' concerns regarding the illness. Conduct the training in a timely manner prior to the start of program activities.

Manage and Monitor the Program

Many challenges exist for managing and monitoring C4D interventions. Among the key challenges are:

- Lack of a structured (e.g., centrally based) management/supervision plan in place for MNCH program managers
- Inadequate skilled personnel to manage/supervise, monitor, and evaluate communication activities around MNCH at all levels
- Inadequate monitoring and evaluation mechanisms/tools for communication activities
- Insufficient human and material resources dedicated for supportive supervision, monitoring, evaluation
- Insufficient financial resources dedicated for supportive supervision, monitoring and evaluation
- The recognition that monitoring and evaluation are essential to implementing efficient and effective strategic plans

There are several opportunities for addressing the management and monitoring challenges, including:

- Defining a plan or structured process for the management and supportive supervision of MNCH interventions
- Drawing on partnerships with organizations for implementing routine MNCH supervision and monitoring (e.g., sharing costs)
- Developing or refining supervision tools and performance criteria
- Considering performance-based incentives
- Developing or refining monitoring tools (e.g., checklists) and indicators
- Using information and communication technologies (e.g., mobile phones) to facilitate date collection and track program interventions

C4D program managers need reliable and timely information about program activities. Monitoring, also referred to as process evaluation, is the routine (day-to-day) tracking of activities and deliverables to ensure that materials are being distributed to the right people in the right quantities, messages are being delivered, partners are involved, and the program is proceeding as planned, on schedule, and within budget. Program monitoring alerts managers to problems or deviations from the program plan in a timely manner, provides information for improved decision-making, ensures more efficient use of resources, and strengthens accountability of the program. Monitoring can also help you to measure the intended populations' reactions to program interventions in a timely manner so that adjustments to messages, materials, or activities can be made in a timely manner.

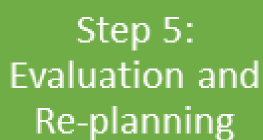
You should plan to measure the INPUTS (i.e., the resources that go into the program, for example, staff, volunteers, time, money, equipment, and materials) and OUTPUTS (i.e., the activities, services, events, and products that reach your intended populations) so that you know who is doing what, whether you are staying within budget and within your timeline for implementing your program (Examples of What to Monitor and Questions to Ask).

Process/Monitoring Indicators

Table 7 provides a list of common process or monitoring indicators for a breastfeeding promotion intervention. These indicators can be adapted to other program components. The Checklist for Program Monitoring Activities will help you to organize the activities and indicators for your C4D interventions.

Table 7. Common Process/Monitoring Indicators for Breastfeeding Promotion Intervention.

Process (Monitoring) Indicators
Training Indicators • Curriculum development completed • Trainings for providers completed for breastfeeding counseling • Trained providers who are knowledgeable in breastfeeding counseling **Message and Materials Development Indicators** • Focus groups completed • Breastfeeding communications products developed • Dissemination plan developed • Breastfeeding communications materials disseminated • Intended population exposed to messages/materials on breastfeeding **Policy Development Indicators** • Decision made by policy working group to write national breastfeeding policy • Existence of national breastfeeding policy • Existence of national breastfeeding plan • New policy implemented **Monitoring and Evaluation Progress Indicators** • Identification of necessary technical assistance • Completion of approved evaluation plan • Development of data collection forms • Completion of data collection • Evaluation activities completed



Step 5: Evaluation and Re-Planning

Evaluation is a systematic way of gathering evidence to show what program activities produced the intended results and which did not achieve the expected results for the specified intended populations. The evaluation is designed specifically with the intention to attribute changes to the program interventions.

Evaluation measures the outcomes (short-term and medium-term) to determine changes in your populations of interest (individuals, households, communities, organizations, policymakers) as a result of exposure to your program interventions). The short-term outcomes are the changes in awareness, knowledge, attitudes, beliefs, self- and collective- efficacy, skills, intentions and motivations of the intended population members. The medium-term outcomes are the changes in the behaviors, practices, decision-making processes, power relations, policies and social norms as a result of program activities. Medium-term outcomes usually take longer to realize than short-term outcomes. The program impact is the long-term change in the social, economic, policy, and environmental conditions that result from the C4D program initiatives. Not all programs have the time and budget to measure the long-term impacts, as these might not be realized until after the program has ended.

Select an Evaluation Design and Methodology

There are many ways to evaluate a C4D program and the most appropriate will depend on the financial resources and capacities available, the types of questions that are to be answered, and the timeframe allotted. **Quantitative** and **qualitative** data collection methods are both important for assuring the broad strokes and nuances of changes produced by the program are adequately captured. The overall questions to answer are “How well have we done?” and “How can we do better?” (see Module 2, p.27). For example, a MNCH program in Pakistan conducted an independent evaluation to:

1. Assess whether the MNCH program has achieved the intended goals, objectives, and outcomes as described in the Cooperative Agreement and its amendments and work plans;
2. Evaluate the effectiveness of key technical inputs and approaches of the MNCH program in improving the health status of mothers, newborns, and children compared to baseline and mid- term health indicators where available;
3. Explore the impact of PAIMAN’s technical approach on maternal, neonatal, and child morbidity and mortality in at least the 10 districts originally covered by the project, as much as possible with the current available data; and
4. Review the findings, conclusions, and recommendations, and provide brief suggestions and/or options for ways in which project components might be strengthened or continued and scaled up by the GOP’s health entities (Ministry of Health [MOH], Ministry of Population Welfare [MOPW], provincial and district counterparts)

The evaluation methodology consisted of:

- Review of background documents
- In-depth discussions with relevant program staff
- Structured in-depth interviews with relevant government representatives, donor organizations, implementing partners, and other stakeholders
- Site visits and observations to project offices and to observe service delivery, training, and community interventions, during which the team interviewed health managers, service providers, trainees, and community members
- Focus group discussions
- Informal group discussions

The evaluation team used both qualitative and quantitative methods during the evaluation. Quantitative information was derived from data collected by the program (e.g., baseline, midterm and endline survey data), District Health Information System (DHIS) data, Demographic and Health Survey (DHS) data, Multi-Indicator Cluster Survey (MICS) data and other sources. Qualitative information was collected by an evaluation organization through interviews, focus group discussions, and observations at health facilities**.** To ensure that comparable information was collected during field visits, the team drafted standard interview guides. These data collection tools were designed to reflect the questions posed by the scope of work and were used to interview various health managers and providers Pakistan (PAIMAN) Maternal, Newborn, and Child Health Program Evaluation).

Realistically, most programs hire an external evaluator or evaluation organization to assess their progress toward their objectives and goal(s). Nevertheless, it is good to know at least some of the common indicators for success as a result of your interventions (Table 8).

Data Collection Methods

There are usually challenges regarding the availability of quality data for evaluating MNCH programs. Existing government and partner tools can be limiting; government health workers, community health workers, and partners may have limited capacity (and low remuneration) for implementing evaluations, and communities in remote locations may be difficult to access. It is important to assess the limitations so that you are able to collect the data you need for your program evaluation.

There are many methods for collecting quantitative and qualitative data (Common Evaluation Data Collection Methods and Descriptions). The method(s) selected for an evaluation will depend on (1) the purpose of the evaluation, (2) the users of the evaluation, (3) the resources available to conduct the evaluation, (4) the accessibility of study participants, (5) the type of information (e.g., generalizable or descriptive), and (6) the relative advantages or disadvantages of the method(s). All evaluations should aim to use mixed methods, that is, a combination of quantitative and qualitative methods in order to capture multiple facets of the program outcomes/impacts, and to be able to triangulate the findings.

Table 8. Common Outcome C4D-Related Indicators for MNCH Interventions.

Outcome Indicators

Antenatal Care

- Percentage of women/caregivers who know the importance and time interval of 4 ANC visits
- Percentage of pregnant women with at least 4 ANC visits

Malaria Prevention

- Percentage of pregnant women using insecticide-treated bed nets

Danger Signs

- Percentage of women/caregivers who can identify maternal danger signs

Birth/Delivery

- Percentage of women and families who have planned for birth by saving money, arranging transportation, arranging blood donation, and identified a skilled birth attendant
- Percentage of births attended a skilled birth attendant or in a health facility

Newborn Care

- Percentage of women/caregivers who can identify newborn danger signs
- Percentage of women/caregivers who can identify where to access newborn health services
- Percentage of women/caregivers who know the Essential Newborn Care Practices
- Percentage of mothers with three postnatal care check ups by trained health worker after delivery
- Percentage of women/caregivers who practice Essential Newborn Care
- Percentage of women/caregivers who seek immediate care for diarrhoea, pneumonia, malaria and other conditions

Breastfeeding

Knowledge About Exclusive Breastfeeding

- Knowledge of the key benefits of exclusive breastfeeding
- Knowledge of the recommended duration for exclusive breastfeeding

Attitudes Toward Exclusive Breastfeeding

- Positive attitudes toward exclusive breastfeeding

Breastfeeding Rates

- Exclusive breastfeeding rate <6 months
- Exclusive breastfeeding rate months 0, 1, 2, 3, 4, and 5
- Never breastfed rate

Timely Initiation of Breastfeeding

- Initiation of breastfeeding in first hour of life

Duration of Any Breastfeeding

- Continued breastfeeding rate at 12 months
- Continued breastfeeding rate at 24 months
- Mean duration of breastfeeding

Intensity of Breastfeeding

- Frequency of breastfeeding in 24 hours
- Full/partial/token breastfeeding
- Mean duration of lactational amenorrhea

Timely Complementary Feeding

- Timely complementary feeding rate

Self-Efficacy for Exclusive Breastfeeding

- Confidence to exclusively breastfeed for six months

Immunization

- Percentage of children who are fully immunized

Other

- Percentage of policymakers that provide dedicated support for MNCH services
- Percentage of community leaders that provide resources for MNCH services
- Percentage of religious leaders that talk to women and families about appropriate healthcare throughout the MNCH continuum of care

Revise and Re-Planning the Program

The program evaluation will reveal (1) the weaknesses of the interventions in achieving the program objectives, and point to areas that can be revised and strengthened, and (2) highlight what worked well and how those positive outcomes can replicated, and even scale up. The evaluation findings should feed forward into the design of similar, future programs.