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National Social and Behavior Change Communication Sub-Strategy for Maternal, Newborn and Child Health

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National Social and Behavior Change Communication Sub-Strategy for Maternal, Newborn and Child Health 2012–2015

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired ImmuneDeficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASM	Agent de Santé Maternelle
BCC	Behavior Change Communication
BCG	Bacillus Calmette - Guerin vaccine
BSS	Behavioral Surveillance Survey
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CHF I-Rwanda	CHF International Rwanda
CHW	Community Health Worker
CNLS	Commission Nationale de LutteContre le SIDA (National AIDS Control Commission)
DHS	Demographic and Health Survey
DPT3	Diphtheria, Tetanus and Pertussis Vaccine
EDPRS	Economic Development and Poverty Reduction Strategy
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EIP	Expanded Impact Child Survival Program/KABEHOMWANA
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Program on Immunization
FAM/IRH	Fertility Awareness Methods/Institute for Reproductive Health
FANC	Focused Antenatal Care
FHI 360	Family Health International
FP	Family Planning
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
IHDPC	Institute for HIV and Disease Prevention and Control
IMCI	Integrated Management of Childhood Illness
IPC	Interpersonal Communication
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JSI	John Snow, Incorporated
KAP	Knowledge, Attitudes and Practice
KMC	Kangaroo Mother Care
LLIN	Long-Lasting Insecticide-Treated Net
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program

MDG	Millennium Development Goal
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MTCT	Mother-to-Child Transmission
NGO	Nongovernmental Organization
OPV3	Oral Polio Vaccine
ORINFOR	Office Rwandaisd'Information (Rwanda Information Authority)
OVC	Orphans and Vulnerable Children
PAC	Postabortion Care
PEP	Post-Exposure Prophylaxis
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNILP	Programme National integré de Lutte Contre le Paludisme (National Integrated Malaria Control Program)
PNILT	Programme National Integré de Lutte Contre la Tuberculose (National IntegratedTuberculosis Control Program)
PSI	Population Services International, Inc.
RBC	Rwanda Biomedical Center
RDHS	Rwanda Demographic and Health Survey
RH	Reproductive Health
RHCC	Rwanda Health Communication Center
SBCC	Social and Behavior Change Communication
SGBV	Sexual and Gender-Based Violence
SIDA	Syndrome d'immuno Déficience Acquis (Acquired Immune Deficiency Syndrome)
SMS	Short Message Service
STI	Sexually Transmitted Infection
TB	Tuberculosis
TB & ORD	Tuberculosis and Other Respiratory Diseases Division
TRAC	Treatment and Research AIDS Center
U5	Under Five
UNFPA	United Nations Population Fund
UNICEF	United Nations Children'sFund
UPHLS	Umbrella des Personnes en situation de Handicap Luttant contre le VIH & le SIDA
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WVI	World Vision International

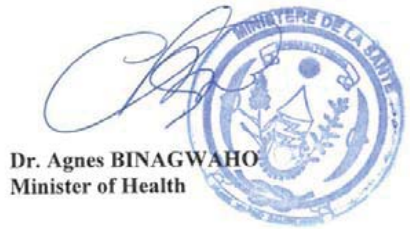
FOREWORD

Rwanda is making progress toward reaching the Millennium Development Goals of reducing child mortality, improving maternal health and combating infectious diseases. In terms of the nation's health, Rwanda has much to be proud of. During the past five years, maternal, infant and child mortality rates have decreased, malnutrition has declined, contraceptive use has doubled, "*mutuelles de santé*" have gained momentum and the country has developed one of the best child vaccination programs in Africa.

However, there are still many challenges to be met. Most illness and death is caused by communicable diseases such as tuberculosis, malaria and infectious diseases of childhood, and HIV and AIDS continue to have an impact on public health. Malnutrition contributes to these deaths. Social and Behavior Change Communication (SBCC) is known to play a pivotal role in preventing malnutrition and disease transmission, controlling vectors, improving hygiene and sanitation, and creating demand for service provision, resulting in a healthier population.

This *National Social and Behavior Change Communication Sub-Strategy for Maternal, Newborn and Child Health* builds heavily on the *National Behavior Change Communication Policy for the Health Sector*, developed in 2006, and support its essence, as well as other relevant policies and national planning instruments. It provides a strategic orientation and guiding principles to achieve priority health objectives, and also serves as a practical planning framework to guide SBCC implementation.

Because of the importance of SBCC in health improvement, the Ministry of Health encourages all development partners to support the implementation of this integrated strategy. The Ministry of Health is committed to ensuring that the necessary mechanisms be put in place and resources identified to continually integrate SBCC with health planning, programming and implementation in order to ensure better health for all Rwandans.



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Our appreciation goes to the Management of the following institutions and persons given in alphabetical order—for the expertise availed through their SBCC specialists[1]:

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Special thanks go to the Jhpiego-led MCHIP project in Rwanda and its partner PATH for their contribution to the health sector by successfully supporting the process of developing the present SBCC Sub-Strategy for Maternal, Newborn and Child Health.

The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.
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1. INTRODUCTION

In Rwanda, as in other sub-Saharan countries, preventable diseases still claim the lives of mothers and children, despite the fact that these diseases can be largely avoided through health promotion and sustained behavior change interventions. The Government of Rwanda has increasingly recognized the role that behavior change communication can play in improving the health status of mothers, infants and young children; reducing causes of maternal deaths and poor birth outcomes; and increasing the use of family planning and healthy timing and spacing of pregnancies, as well as preventing malaria, HIVand TB; improving hygiene and sanitation; and creating demand for quality service provision. Behaviors that contribute to attaining these key health and nutrition goals can be encouraged through a myriad of communication channels and lead to achieving the Millennium Development Goals (MDGs) and a healthier Rwandan population.

The National Social and Behavior Change Communication (SBCC) Sub-Strategy presented in this document focuses on maternal, newborn and child health (MNCH). It is intended as a living guidance document for use by the Ministry of Health (MoH), the Rwanda Health Communication Center, donor agencies and development partners in health communication planning, implementation, coordination, monitoring and evaluation. The aim of integrating social and behavior change communication into health planning, programming and implementation is to facilitate the adoption and maintenance of a wide range of key, prioritized, health-related behaviors for high impact and effect on attaining the MDGs, conducive to improving health and reducing the burden of morbidity and mortality in Rwanda. This Sub-Strategy identifies critical behaviors to focus on over a discrete period of time—2012 to 2015; the larger menu of behaviors will be phased in over time, as the most important behaviors attain wide coverage. This SBCC Sub-Strategy for MNCH specifically addresses key elements also identified in the National Behavior Change Communication Policy for the Health Sector, the development of which was recommended in the Health Sector Strategic Plan 2005–2009. These key elements include the following:

- Definition of the contribution of SBCC in achieving national health priorities
- Provision of a strategic orientation and guiding principles to achieving priority health objectives through SBCC
- Provision of guidance and tools to support SBCC planning, programming, coordination and evaluation

In the recent past, most health education in Rwanda has been based on information, education and communication (IEC) campaigns. These campaigns provided people with factual information about health issues, for example, informing people about diseases and how to avoid them. The assumption is that once people have the relevant information, they will choose healthy behaviors over risky behaviors. However, individuals make decisions about their health not only based on factual information, but also in relation to the social and cultural environments in which they live. Evidence now suggests that providing information through mass media or IEC campaigns is not enough to persuade people to change. Influencing health behaviors requires a multifaceted approach to communication that considers the

complexities of culture, gender, power, economics, emotions, social relationships and social skills.

The development of this national SBCC Sub-Strategy for MNCH followed a consultative process involving government institutions and development partners from international non governmental organizations (NGOs), United Nations agencies, civil society organizations and the media. The experience of each was valued and expertise of each institution was exploited to capture their concerns and develop a strategy that will address challenges prevailing in the field.

The National Behavior Change Communication Policy for Health Sector provides a strong foundation and clear direction for strategic planning, implementation, monitoring and evaluation of this national Behavior Change Communication Sub-Strategy on Maternal, Newborn and Child Health Additionally, other policies such as the family planning policy and special programs have been designed and are being implemented to combat malaria (the National Malaria Control Program, or PNILP), HIV and AIDS through Rwanda Biomedical Center/Rwanda Institute of HIV and Disease Prevention and Control, and tuberculosis through the Rwanda Biomedical Centre/ Institute of HIV and Disease Prevention and Control (IHDPC)/Tuberculosis and Other Respiratory Diseases (TB&ORD) Division (formerly the National Integrated Tuberculosis Control Program or PNILT). A multisectoral strategic plan 2010–2013 to eliminate malnutrition has been developed and is being implemented by various stakeholders supporting the implementation of District Plans for the Elimination of Malnutrition. Vitamin A supplementation has been associated in field distribution points with the Expanded Program on Immunization (EPI). In all cases, communication for behavior change plays an important role in ensuring prevention of illness through adoption of healthier lifestyles as well as increasing demand for and improving access to health care services.

This national SBCC Sub-Strategy for MNCH has prioritized behaviors in health and nutrition that will have an immediate impact on the reduction of malnutrition in children, as well as maternal and child mortality.

1.1. BACKGROUND

Rwanda is among the low-income countries in the world, with one of the highest population densities[2] and a total population of about 11 million people.[3] Progress is challenged by poor institutional capacity, insufficient skilled labor and the low educational level of the population.[4]

Given that Rwanda aspires to become a middle-income country, the Government of Rwanda has developed reference development frameworks and other planning tools to address the key challenges. These frameworks are based on the MDGs and include the Rwanda Vision 2020 and the Economic Development and Poverty Reduction Strategy (EDPRS), both of which inspired a number of policies and strategies currently being implemented and/or supported by development partners, including the United Nations Agencies, multilateral and bilateral development agencies, and civil society organizations—with the goal to contribute to the achievement of health-related MDGs targeting the reduction of stunting as well as

[2]Population density per km^2 is 351 as per 2010 RDHS.
[3]Preliminary 2010 RDHS.
[4] Literacy rate in the general population is only 70.4%; women's literacy expressed as a percentage of men's literacy is 88% per UNICEF statistics. http://www.unicef.org/infobycountry/rwanda_statistics.html.

infant and maternal mortality rates. National- as well as community-level initiatives seek to combat diseases such as HIV, malaria and tuberculosis, addressing specific constraints or health challenges of the most vulnerable groups. They also include efforts to improve the quality and delivery of health services, raising population awareness on health issues, undertaking preventive measures and ensuring that there is an enabling policy and a legal framework for better health outcomes.

1.1. 1 Millennium Development Goals (MDGs)

The MDGs outline the global consensus on what constitutes the human development strategic guiding document. They lay normative ground for international development assistance and enable a more streamlined and results-oriented approach to human development. Rwanda is among the 147 countries that agreed to a global pact to give due priority to issues of poverty and development, including to reduce child mortality and improve maternal health. In this endeavor, Rwanda is committed to implement key strategies, through global partnerships, to reduce child mortality by improving maternal, newborn and child nutritional status and health; to decrease maternal mortality, HIV and AIDS infection and related morbidity, and the incidence of malaria and other diseases; and to ensure environmental stability.

The table below summarizes the Millennium Development Goals and the target figures for Rwanda.

Table 1: Millennium Development Goals

	Millennium Development Goals (all goals set as improvements between 2000 and 2015)	2000	2005–6	MDG Goal	Value 2010
Goal 1. Eradicate extreme poverty and hunger	Halve the proportion of people living under one dollar a day	60.4%	56.9	25%	57
	Proportion of under 5 underweight	24%	23	15%	11.4
Goal 2. Achieve universal, primary education	Have all children enrolled in primary school	72.0%	95	100%	95.4
	Have all children completing primary school	22%	51.7	100%	75.6
	Ensure full literacy rate for 15- to 24-year olds	57.4%	76.8	100%	–
Goal 3. Promote gender equality and empower women	Eliminate the gender gap in primary education	0.0%	0.0	0%	–
	Eliminate the gender gap in secondary education	-%	–	0%	–
	Eliminate the gender gap in literacy	0.1%	–	0%	0.1
Goal 4. Reduce child mortality	Reduce by two-thirds the under-5 mortality rate (per thousand births)	196	152	50	76
	Reduce by two-thirds the infant mortality rate (per thousand births)	107	86	28	50
	Have all 11-to 23-month-old children immunized against measles	74%	95	100%	–

	Millennium Development Goals (all goals set as improvements between 2000 and 2015)	2000	2005–6	MDG Goal	Value 2010
Goal 5. Improve maternal health	Reduce maternal mortality by three-quarters (per 100,000 births)	1071	750	268	383
	Have all births attended by skilled health personnel	31.3	38.6	100%	69
Goal 6. Combat HIV/AIDS, malaria and other diseases	Stabilize or reduce HIV/AIDS prevalence	13% (1997)	3.5	5.1%	3
	Increase proportion of children under five sleeping under insecticide-treated net	–	59.7	–	70.5
	Increase contraceptive prevalence among women aged 15 to 49	13.2%	17.4	n/a	45
	Population 15 to 24 years old with comprehensive, correct knowledge of HIV and AIDS	20	53.6 MDG country report	–	–
	Access to anti-retrovirals	–	52	–	71 (in 2007)
Goal 7. Ensure environmental sustainability	Population with access to improved drinking water source	65	65	–	–
	Population with access to improved sanitation facility	25	60 MDG country report 2007	–	–
Goal 8. Develop a global partnership for development	Cellular subscribers	0.5	3.4	–	–
	Internet users	0.06	1.08	–	–
	Telephone lines	0.23	0.26	–	–

1.1.2 Rwanda Vision 2020, a Strategy to Reach the MDGs

The global vision of the Government of Rwanda set out in Vision 2020, a strategy to reach the Millennium Development Goals, is to guarantee the well-being of the population by increasing productivity and reducing poverty within an environment of good governance. As part of this vision, the government seeks to overcome illnesses linked to poverty and ignorance, and to develop a proactive and well performing health system capable of anticipating and appropriately responding to the health needs of the population.

The related indicators from the Vision 2020 document, as well as the mid-term benchmarks, are summarized in the table below.

Table 2: Vision 2020 Indicators

Indicators	Situation in 2000	Situation in 2005	Situation in 2010	Objective 2015	Objective 2020
Rwandan population (millions)	7.7	8.5	10.6	10.2	13 (Vision 2020) 14.4 pop policy 2010
Life expectancy at birth (yrs)	49	–	57.47	50	55
Population growth rate (%)	2.9	–	2.62	2.3	2.2
Total fertility rate	6		4.6	5.5	4.5
Infant mortality rate	107	86	50	80	50
Maternal mortality ratio	1,071	750	383	268	200
Child stunting rate	48	51	44	–	–
HIV and AIDS prevalence rate (%)*	13	3.5	3	11	8
Malaria-related mortality rate	51	26		30	25

** Above estimates of AIDS prevalence were based on biased data. The DHS+ 2005 survey showed an overall prevalence of HIV sero-positive rate of 3%.*

In order to reach both the MDGs and the Vision 2020 targets, behavior change is a crucial step, and communication and information are key elements for success. Promotion of behavior change communication is a vital strategy for ensuring the achievement of the Vision 2020 goals.

1.1.3 Economic Development and Poverty Reduction Strategy (EDPRS)

The Economic Development and Poverty Reduction Strategy paper presents the government's vision for reducing poverty and stimulating economic growth. The EDPRS is used as an analytical framework, with health placed at the center of key issues and dimensions of poverty. The document emphasizes the importance of SBCC in almost all areas of health interventions. The EDPRS states that "*information on preventive health and some very basic curative techniques would deal with most of the major diseases affecting the people of Rwanda, which includes malaria, HIV and AIDS, and child diarrhea, etc. Public information will be promoted for all preventable diseases, using the most cost-effective methods, including radio advertisements and the introduction of health issues into popular dramatic programmes.*" Special attention is given to HIV and AIDS, one of the major, cross-cutting issues affecting the country's economic growth. The first recommended actions for the mitigation of the impact produced by this devastating disease is the prevention of HIV transmission by reinforcing information, education and communication and the promotion of the use of protection.

As a conclusion, the EDPRS emphasizes that "*underlying factors like lack of access to information need to remain a key focus,*" and that "*these interventions will mainly be implemented through sectoral strategy processes.*" Of importance to note, Rwanda is well-endowed with social, political and religious structures that can be harnessed to transmit awareness of the causes of disease and advice about prevention, thus reducing the cost of spreading awareness.

The MoH, through the communication for behavior change policy and other health sector policies, will lead the implementation of the necessary reforms within the health sector and will assist with the other sectors as proposed within the EDPRS document: education sector, social protection and environmental care, rural infrastructure, and housing and community amenities.

1.1.4 The Health Sector Strategic Plan (HSSP)

Demand for and supply of quality health delivery services remain key constraints to development in Rwanda. To ensure that the health of the Rwandan population is improved and national and international targets are met, the Ministry of Health has developed a Health Sector Strategic Plan (HSSP), which provided strategic direction for the health sector. The strategy was centered on primary health care, decentralization, community participation, human resource development, strengthening of the health information system and a multi-sector approach to health.

The current HSSP II (2009–2012) is the second version and aims to sustain and accelerate progress made during the implementation of the first. Key indicators show advances in improving the quality and availability of health care services, and the population has gradually regained its confidence in the health care system. This has led to increased utilization of health services, and a consequent decrease in infant and child mortality, decrease in prevalence of malnutrition, increase in the use of family planning and birth spacing, and prevention and management of communicable diseases such as malaria, acute respiratory infection (ARI) and HIV infection, all leading to improved living conditions and a healthier population.

These improvements in the quality and availability of services were achieved, in part, through decentralizing health care management and service delivery. However, child and maternal health concerns persist, and negatively impact national development.

1.1.5 Specific Health Sector Program Strategies and Plans

The Health Sector Strategic Plans provide programs with operational guidelines and strategies to meet the sector objectives. In these plans, special attention is given to communication, with two stated objectives:

- To promote behavioral change in the population that is favorable to the health of the population through intersectoral collaboration and community participation; and
- To promote healthy lifestyles and disease prevention.

The main actions of the national programs are to:

- Promote the notion of excellence and set standards in the design and delivery of the IEC messages among those responsible for health programs;
- Reinforce the communication skills of service providers and health workers;
- Promote the use of IEC messages targeted to the family;
- Involve the community in communication activities; and
- Promote healthy lifestyles and prevent diseases, with an emphasis on promoting hygiene and addressing unhealthy behaviors—such as drinking alcohol,

smoking, eating unhealthy diets and practicing unsafe sex—through community health workers (CHWs) and mass media campaigns.

It was also recommended that a multisectoral Technical Working Group develop a strategy to address these objectives. This strategy should be informed by the various programs put in place and seek to reach synergy and complementarity of interventions.

1.1.6 The National Behavior Change Communication Policy for the Health Sector

The *National Behavior Change Communication Policy for Health Sector*[5]is one key component of the Government of Rwanda's health policies, plans and guidelines. This policy builds on the *Health Sector Policy* and the *Health Sector Strategic Plan*, and draws from the *WHO Regional Health Promotion Guide* as well as a number of national IEC and SBCC plans and strategies.

The National Behavior Change Communication Policy for the health sector aims at strengthening the implementation of overall development objectives in Rwanda, with specific focus on the health sector. Indeed, the National Policy emphasizes enabling the population to make informed health behavior choices: "*People do not intentionally risk their or their families' health and lives and if empowerment is effective, people are responsive. Providing appropriate information, with quality messages and methods, including use of media, are a start. The challenge, however, is to create the circumstances in which the poor are the prime actors in their programs – in which they are enabled to take action to improve their own health.*"

The current National Social and Behavior Change Communication Sub-Strategy on Maternal, Newborn and Child Health is founded on this communication policy and intends to contribute to Rwanda's efforts to:

- Halve the percentage of malnourished children;
- Halt and begin to reverse the spread of HIV and AIDS by 2015;
- Halt and begin to reverse the incidence of malaria and other major diseases by 2015;
- Reduce by two-thirds mortality rates for infants and under-five children by 2015; and
- Reduce by 75% maternal mortality by 2015.

Indeed, it has been proven that SBCC for health, when it has a human face, can contribute to reductions of child and maternal mortality by removing barriers and maximizing incentives for families to adopt positive behaviors. This sub-strategy will give a human face to motivation, and enable families to act for sustained change.

[5]*National Behavior Change Communication Policy for Health Sector, 2006.*MoH. Rwanda.

2. THE NATIONAL SOCIAL AND BEHAVIOR CHANGE COMMUNICATION SUB-STRATEGY FOR MATERNAL, NEWBORN AND CHILD HEALTH

2.1 DEFINITION OF SBCC

SBCC is an interactive process aimed at changing social conditions and people's behavior. It identifies all the behaviors in need of changing to attain impact.

It is a multi-level tool operating through three key strategies in a planning continuum—advocacy, social mobilization and behavior change communication—for promoting and sustaining healthy, risk-reducing behavior change in individuals and communities. It achieves this objective by disseminating tailored health messages to specific audiences through a variety of communication channels, based on evidence-driven communication objectives.

2.2 PURPOSE OF THE NATIONAL SBCC SUB-STRATEGY FOR MNCH

The process of the SBCC Sub-Strategy for MNCH is to:

- Identify key barriers in people's health-seeking behaviors;
- Provide guidance on key content messages;
- Propose a coordinated and harmonized way to reach target audiences with basic facts using a language, visual medium or other channels that they can understand and relate to;
- Increase their knowledge of factors behind maternal and child mortality;
- Stimulate dialogue and propose content messages to promote adoption of desired behaviors. In this endeavor, communication on HIV and AIDS, gender-based violence to address stigma and any form of discrimination will be undertaken to influence social response.

The ultimate contribution of this SBCC Sub-Strategy for MNCH is to decrease maternal and child mortality rates through generating the demand by adolescent girls, mothers and young people for health services; and effectively promoting improved practices among primary and secondary audiences—identified below—in the areas of: reproductive health, family planning, and voluntary counseling and testing (VCT) for HIV, as well as prevention of mother-to-child transmission (PMTCT) of HIV, prevention of malaria and tuberculosis, prevention and case management of diarrheal diseases in newborns, nutrition standards, support to orphans and vulnerable children (OVC), support and care for people living with HIV and AIDS (PLWHA), and clinical care for opportunistic infections. SBCC can also contribute to improving the quality of services by supporting providers' counseling skills and clinical abilities.

2.3 AREAS OF FOCUS OF THE SBCC SUB-STRATEGY FOR MNCH

Based on priorities established by the Maternal and Child Health Unit in the Ministry of Health, the sub-strategy proposes to focus on key, identified behaviors

over a discrete period of time—2012 to 2015. These behaviors revolve around the following groups of health-related themes:

- Family planning, reproductive health, cervical cancer
- Maternal and newborn health (including focused antenatal care[FANC], emergency obstetric care and Kangaroo Mother Care [KMC])
- Maternal, infant and young child nutrition; environmental health, hygiene and sanitation
- Community and facility integrated management of childhood illness (IMCI), malaria and EPI (including vitamin A and de-worming)
- HIV and AIDS, other sexually transmitted infections (STIs) and tuberculosis (TB)
- Sexual and gender-based violence (SGBV)

2.4 GUIDING PRINCIPLES OF THE SBCC SUB-STRATEGY FOR MNCH

The SBCC Sub-Strategy for MNCH is focused on the following guiding principles:

- *Systematic, participatory planning and community involvement* through the planning continuum from the concept design through message development, communication implementation and evaluation, resulting in community empowerment, skill development and a dynamic, two-way exchange of information and ideas needed to make informed health choices.
- *Use of a combination of strategic interventions*: advocacy, social mobilization and behavior change communication.
- *Integration and use of multiple channels* to address health issues in a holistic way while leveraging resources and maximizing effectiveness through increased exposure and use.
- *Coordination, information sharing and partnerships* between different stakeholders to increase the impact of SBCC interventions.
- Pursuit of the common communication objectives across all interventions on MNCH.
- *Prioritization of evidence-based and results-oriented interventions*, with clearly defined targets, to improve audience knowledge, awareness, motivation, acceptance and skills (action) for the adoption of healthy behaviors.
- High-quality, professionally developed messages, focused on social and behavior change at both the household and community levels, tailored to the target audience, accurate, appropriate, relevant, persuasive and motivating for change.
- Participation, dialogue, problem solving, and interaction within a human rights and gender perspective to give a human face to health messages and increase awareness of the need for equity in gender roles.
- *An orientation to the culture of the audience*, recognizing culture as the building block of any economic and social transformation and mobilizing cultural resources in support of health behavior change communication interventions as appropriate.

- *Abalance between SBCC and improved health services*, with an understanding that the demand for and access to quality health care are fundamental to achieving Rwanda's health goals.
- *A reflection of* the National Behavior Change Communication Policy for the Health Sector.

2.5 ORGANIZATION OF THE SBCC SUB-STRATEGY FOR MNCH

The sub-strategy is organized as follows:

- Situation Analysis and Problem Statement
- Key Problem Behaviors to Address and Behaviors to Promote
- Participant Audiences' Analysis
- Communication Interventions and Channels
- Communication Objectives and Evaluation Indicators
- Strategic Communication Plan
- Additional Research Needed
- Implementation Plan and Budget
- Monitoring and Evaluation Plan

2.6 IMPLEMENTATION MECHANISMS

This SBCC Strategy will be based on overall maternal and child health (MCH) program goals and objectives. It will seek to link communication interventions to services or products that people can access. Inspired by communication models and theories,[6] interventions will move beyond individual communication products to a careful mix of multiple communication interventions, products and channels for a broad community approach. In Rwanda, these approaches have demonstrable impact and therefore should be used to reach and influence individuals and groups to adopt preventive behaviors.

This sub-strategy acknowledges that, often, people need to perceive the benefits of changing their behavior and must have skills to cope with barriers and set backs. Sometimes these barriers are not necessarily related to the quality or the availability of the health information, but underlying and root factors such as non-availability of health care services or products, limited authority or capacity, lack of support from family members, mothers' lack of time, and lack of financial or other resources. An array of communication activities in this sub-strategy will address capacity gaps, particularly at middle and lower levels. These will include community mobilization, training and dissemination of messages through appropriate support tools and channels.

Social and individual behavior changes all the time and changing behavior requires commitment to support people through different stages of change. This is particularly true because some social norms and individual health behaviors take years to change (e.g., attitudes toward vaccination or contraception), and take even

[6]The health belief model, social learning theory, positive deviance, diffusion of innovations and the social ecological systems model.

longer to be reflected in the epidemiology of a community or country (e.g., reduced rates of vaccine-preventable illness or lower birth rates).

To be effective in promoting long-term behavior change, the implementation plan of interventions identified in this SBCC Sub-Strategy for MNCH should encompass an array of campaigns to be rolled out for the three-year implementation period. These campaigns should include branding positive images of mother and child, reinforcing messages during special events and community gatherings, and promoting role models and other community initiatives.

Partnership is crucial to achieving results for maternal, newborn and child health. Partnering with all stakeholders at all levels will be crucial to leveraging resources to reach all audience at central, district and sector levels. National and international NGOs, civil society organizations, health providers, local leaders, CHWs, teachers and community mobilizers, and targeted audiences will be key implementing partners at health facility, community and school levels, as they may interact daily with participant audiences. The planning process will be participatory to include the less privileged and the vulnerable. Reviews will allow for highlighting the gaps identified during the implementation. Progress will be evaluated against target indicators.

2.7 PARTNERSHIP AND COORDINATION MECHANISMS

With a large number of partners involved in health communication activities, coordination was a challenge in the recent past as a number of government institutions led sectoral IEC/SBCC strategies and coordination of plans.

Today, the Rwanda Biomedical Center/Rwanda Health Communication Center (RBC/RHCC) advises the MoH on strategic health communication and is an established focal point for health promotion interventions across all health sectors. However, the understanding of who should coordinate communication for social and behavior change interventions is not yet clear in partners' minds. As a consequence, business continues as in the past, although all interventions are located under the Rwanda Biomedical Center and should have coordinated communication initiatives:

- For the Rwanda Biomedical Center/IHCDP, programming and coordination are guided by an interagency HIV and AIDS SBCC Committee. The Commission Nationale de Lutte Contre le SIDA (CNLS) (National AIDS Control Commission) was the lead agency in collaboratively developing the National Strategic Framework for Behavior Change Communication for HIV and AIDS.
- The National Integrated Malaria Control Program (PNILP) coordinates communication activities for malaria control and prevention and developed a Strategic IEC Plan.
- The Rwanda Biomedical Center/Institute for HIV and Disease Prevention and Control (IHCDP) / Tuberculosis and Other Respiratory Diseases (TB&ORD) Division (formerly the National Integrated Tuberculosis Control Program [PNILT]) oversees IEC activities related to tuberculosis.
- The Expanded Program on Immunization (EPI) coordinates social mobilization to strengthen routine vaccination.
- The Ministry of Education developed a school health policy and coordinates a wide range of school-based health promotion activities.

Development partners, with the United Nations Children's Fund (UNICEF) and World Health Organization (WHO) providing overall guidance, contribute each according to their comparative advantage in planning and implementation of communication interventions at the local level. (See Appendix 2: Partners' Mapping.)

This SBCC for MNCH proposes to have an integrated coordination mechanism. As all interventions feed into the health sector, particularly mother and child health, the MoH, Division of Maternal and Child Health, would lead the overall coordination of all interventions, to ensure that communication, quality of service and supply of products go hand in hand. While the Rwanda Health Communication Center would facilitate the production of materials, the content of health messages is the responsibility of the MCH unit. Therefore, a content development workshop, and agreement on tools to be disseminated, should occur under the coordination of the MoH, MCH Division. MCH will equally coordinate interventions in the field and assure equity, as well as control duplication, overlapping or even contradiction in messages taken to the communities. Each partner or group of partners provides quarterly reports to the MCH division, which will regularly convene stakeholders' planning review meetings to address issues that may need common agreement.

3. SITUATIONAL ANALYSIS AND PROBLEM STATEMENT

3.1 MATERNAL AND CHILD HEALTH SITUATION

Remarkable progress has been made in the health sector in Rwanda with regard to child health indicators. A number of interventions such as vitamin A supplementation, the use of insecticide-treated bednets to prevent malaria, promotion of exclusive breastfeeding and immunization, particularly against measles and pneumonia, have shown great impact in improving child survival. The under-five mortality rate decreased from 152 per 1,000 live births (RDHS 2005) respectively to 103 (RIDHS 2007–8) and 76 (RDHS 2010). The child mortality situation improved from 72 deaths per 1,000 live births in 2005 to 47 per 1,000 live births in 2007 and 27 per1,000 live births in 2010. The infant mortality rate decreased from 86 deaths per 1,000 live births in 2004 to 62 per 1,000 live births in 2008 and 50 per 1,000 live births in 2010. In the same vein, the postnatal mortality rate declined from 49 per 1,000 live births (RDHS 2005) to 34 per 1,000 live births in 2008 and 23 per 1,000 live births in 2010. In addition, the neonatal indicators changed from 37 per 1,000 in 2005 to 27 per 1,000 (RDHS2010).

Most maternal deaths in Rwanda are linked to illnesses and unpredictable complications during pregnancy or delivery. These include malaria, hemorrhage, infections, eclampsia and prolonged obstructed labor, as well as unsafe abortions. The current health package to prevent most of these conditions includes quality reproductive health services, promotion of the four minimum antenatal care visits and delivery in health facilities assisted by trained providers. As a result of these focused interventions, maternal health indicators have improved over the years, and the maternal mortality ratio declined from 750 per 100,000 live births (RDHS 2005) to 476 per 100,000 live births (RDHS 2010).

These gains have been reached through combined stakeholders' efforts to promote:

- Family planning, raising the percentage of women aged 15–49 using modern contraceptives from 10% in 2005 to 45% (RDHS 2010) and practicing birth spacing;
- Sleeping under long-lasting insecticide-treated nets (LLINs), coupled with increased communication and health and environmental care interventions, which has seen the indicator for percentage of pregnant women aged 15–49 years sleeping under LLINs reach 73%. For children under five, it increased from 60% in 2008 to 71% in 2010 (RDHS), resulting in a decline in severe cases of malaria, with the prevalence rate of 2.1% (RIDHS 2007–8) in the general population, and the prevalence rate declining from 2.6% to 1.4% between 2008 and 2010 for under-five children.
- Prevention and control of preventable communicable infections as well as promotion of good nutrition. HIV prevalence in the Rwandan population was 3% (RDHS 2005). Most people living with HIV and AIDS have access to prophylaxis and antiretroviral drugs, and treatment of STIs is accessible. PMTCT programs offered at health centers provide couples living with HIV infection the chance of having children free of HIV. Furthermore, the level of awareness about PMTCT is satisfactory. More than 80% of people interviewed are aware that an HIV-

positive pregnant woman can infect her child through pregnancy and breastfeeding, and that to reduce the risk of transmitting the infection to her child; a mother should consult a health worker. Overall, 75% of the interviewed youth had positive attitudes toward PLWHA. Slightly above half of the interviewees, 52%, had ever heard of HIV and AIDS, and 68% of those who ever had sex reported having had voluntary testing. HIV is also linked to STIs, and the majority of the youth population knows that HIV can be contracted through unprotected sex with an infected person. The tuberculosis case detection rate was reported at 60% by Treatment and Research Center (TRAC) Plus (Global Tuberculosis Control WHO Report, 2011) and accounts for 32% of HIV-related opportunistic diseases.

However, despite the strides made in improving maternal, newborn and child health, more efforts and synergies are needed to sustain the gains toward the MDG targets of 300 maternal deaths per 100,000 live births and having all births attended by skilled health personnel. This sub-strategy aims to complement programmatic interventions with social and behavior change communication focusing on key, high-impact interventions. These include maternal and newborn health, infant and young child nutrition practices including exclusive breastfeeding, consistent use of family planning methods and HIV primary prevention, treatment for ARI and community IMCI, hygiene promotion including handwashing with soap, sanitation and environmental care, and consistent use of LLINs, as well as interventions to address sexual and gender-based violence.

The recent RDHS 2010 report highlights the following challenges to the maternal and child health situation:

1. *Family planning and reproductive health for maternal and newborn health are not optimally used*: The majority of girls and women of reproductive age do not participate in reproductive health programs and fail to follow the four recommended antenatal care (ANC) visits. A health center report states that non-adherence to family planning—leads to frequent, un-spaced and unwanted pregnancies among adolescent girls and women, resulting in unsafe abortion, unassisted home deliveries and failure to adhere to child health care management. The RDHS 2010 shows that 55% of women aged 15–49 and 48% of women aged 25–39 in union do not use modern contraceptives. Only 35% of pregnant women had the four recommended ANC visits; 29% were not protected against neonatal tetanus; and 31% of pregnant women who delivered did not deliver in a health facility and were not assisted by a skilled health provider. Of all five provinces, the Northern Province is the most at risk, with 37% of pregnant women not seeking adequate health care. Overall, only 57% of women with no education delivered in a health facility. As a consequence, there are still concerns about maternal and infant mortality and morbidity.The same RDHS 2010 shows the following: the neonatal mortality rate is 27/1,000 live births; the postnatal mortality rate is 23/1,000 live births; the infant mortality rate is 50 deaths per 1,000 live births; the child mortality rate 27 deaths per 1,000 live births; and the under-five mortality rate is 76 deaths per 1,000 live births.
2. *Infant and young child nutrition,* including exclusive breastfeeding and appropriate infant and young child complementary feeding, remains a challenge. Fifteen percent of children below the age of six months are not exclusively breastfed. Some mothers report giving hot water or milk, while others may give any other available liquid. Furthermore, the majority of mothers, particularly

those in rural areas, give the child food as early as four to five months of age. The introduction of complementary feeding does not follow the infant and young child nutrition protocol. The nutritional status of children raises concerns. The rate of stunted children (height for age) is quite high, 44%, and 17% of those are severely stunted cases. The rate of wasted children (weight for height or thin due to illness) is 3%, and the rate of underweight children (acute and chronically under-nourished) is 11%.

3. Mothers do not complete the *immunization*s schedules for their children. Data revealed that 10% of children aged 12–23 months are not fully vaccinated and hence are exposed to preventable diseases. Advanced strategies must be adopted to reach the hard to reach, particularly when new vaccines are introduced, such as pneumococcal vaccine to prevent ARIs in children under five or HPV for adolescent girls to protect them against cervical cancer.
4. Families do not follow *hygiene and environmental practices* including handwashing with soap, disposal of feces and home ventilation.
5. *IMCI*: Mothers and caregivers do not seek early care from skilled health providers when their children fall sick. Despite health promotion initiatives and sensitization on causes, prevention and management of malaria, ARI, fever and diarrhea, some mothers and caregivers still consider them "as part of life." Mothers/caretakers may not have appropriate knowledge of symptoms and signs of malaria,[7]or skills to manage convulsions, and therefore resort to self-medication practices, leading to inadequately managed cases and recurrence or drug resistance and death. In the two weeks preceding the survey, 4% of under-five children had symptoms of ARI, 16% had fever and 13% had diarrhea. Among these children, those managed at a health facility or by a health provider were found to have the following problems: 50% had ARI, 35% were fever cases, 37% had diarrhea and 30% did not sleep under a mosquito net.
6. Despite being one of the leading causes of maternal and infant morbidity and mortality in Rwanda, *malaria* is still under-perceived, particularly by the most vulnerable groups and some pregnant women. These groups forsake life saving practices and resort to presumptive diagnosis and self-prescription because they resent the cost involved in seeking care at the heath facility; this happens particularly among people who are not subscribed to the community health scheme "mutuelle."
7. *HIV prevention among youth*: Young people have limited comprehensive knowledge of modes of transmission and prevention of HIV and AIDS, both primary prevention and PMTCT. According to the Behavioral Surveillance Survey (BSS) (2009), among youth aged 15–24 years, although 94% of young people heard of HIV and AIDS, only 12% of them have complete and accurate understanding about HIV, i.e. comprehensive knowledge about modes of transmission and prevention methods. Of these, only 29% believe faithfulness to one uninfected partner can protect against HIV, and 16% still ignore that proper use of condoms can protect against HIV and AIDS. In addition, 16% do not confirm that a healthy looking person can be HIV-positive, 29% are not sure that mosquito bites do not transmit HIV and 16% do not know that HIV is not transmitted through sharing a meal with an HIV-infected person. Discrimination and stigma therefore persist within the family, community and workplace.

[7] This issue needs further research—knowledge, attitudes and practice (KAP) or quick assessment—to establish the facts.

8. *Prevention of mother-to-child transmission of HIV (PMTCT):* Although couples are sensitized to both using condoms and limiting sexual intercourse to one uninfected partner as ways to reduce HIV infection, only 28% of men and 29% of women reported having used a condom in their last sexual encounter, and 21% of men and 15% of women do not know that limiting sexual intercourse to one uninfected partner reduces the risk of HIV infection. Among people 15–49 years of age, 26% of men and 21% of women do not know these two HIV prevention methods. Also, the risks of HIV-infected mothers infecting their newborns is still of concern. Today, the HIV prevalence rate among pregnant women in PMTCT services is at 2.7%.[8]In all cases, women living with HIV are more vulnerable to adverse effects than men, and have a greater risk of infecting their children if they do not follow the advice they receive from skilled health providers. Resenting their husbands' reaction and fearing stigma from their family-in-law are some of the underlying causes that may be addressed through promotion of male involvement in PMTCT.
9. *Sexual and gender-based violence (SGBV)* is not well-reflected in real numbers, although it is an increasingly common phenomenon. The number of cases reported in 2010 alone was 1,654. However, this figure does not reflect the magnitude of the issue because an increasing number of girls and women who are sexually and physically abused do not seek support, counseling and treatment. Cultural barriers are linked to shame and fear of discrimination, sex being taboo. Some of the consequences of SGBV are unwanted pregnancies and unsafe abortion, leading to maternal and child death.
10. *Tuberculosis:* According to the new WHO estimates, the TB case detection rate is at about 60%.[9]This is still below the target, which is to detect at least 70% of expected cases. The trend in the notification has shown a continual increase from 1995 until 2006, which was closely associated with the HIV and AIDS epidemics. Since 2007, the number of TB cases started decreasing slightly, by about 3% per year. The number of infectious cases remained stable until 2009, with about 4,200 cases per year, and then dropped to 3,785 in 2010. For the same year, the total number of cases notified (all forms) was 7,065; 75% of the new cases had pulmonary TB, out of which 68% were infectious and 32% were HIV-positive. The Rwanda National TB Control Strategic Plan 2009–2012 provided room for communication-based initiatives. It considered a comprehensive advocacy, social mobilization and SBCC strategy for TB control essential to increase the population's awareness about the signs and dangers of contracting TB.

3.2 PROBLEM STATEMENT

Maternal, newborn and child mortality in Rwanda remains one of the key challenges to the country's development agenda. Despite the efforts made to decentralize the health services and to put in place mechanisms to ensure that every mother and child have access to quality health care, individual and community behaviors and practices still put maternal and childhealth at stake.

Data from HIMS, RDHS and community health center records report:

- Frequent, un-spaced and unwanted pregnancies among adolescent girls and women, leading to unsafe abortion, unassisted home delivery, hence maternal and newborn deaths.

[8]HIV Annual report 2009–2010 (Rwanda).
[9] Global Tuberculosis Control WHO Report, 2011.

- Non-exclusive breastfeeding of the infant up to six months and inadequate infant and young child complementary feeding between seven and 24 months, leading to stunting.
- Non-completion of the immunization schedule by a proportion of children aged between 12 and 23 months who are thus exposed to preventable diseases.
- Cases of diarrhea, malaria and ARI due to the failure of mothers, family members and communities to adopt hygiene and environmental cleaning practices including handwashing with soap and water, proper disposal of feces, home ventilation, and removal of weeds and waste around homes.
- Inadequate home-based case management and delays in seeking adequate treatment from skilled health providers when the child is sick, leading to drug resistance, recurrence and death.
- Low level of young people's comprehensive knowledge of HIV infection, primary prevention and PMTCT.
- Low level of awareness and case reporting of sexual and gender-based violence.

The immediate causes of poor maternal and newborn health are inadequate use of health services by pregnant women and lactating mothers inadequate child health care management at household level; low awareness of preventive measures including key behavior practices; and delayed health care seeking or referral of sick children presenting danger signs.

Intermediate causes are limited information and knowledge of pregnant women, lactating mother and caregivers about child care practices; inadequate home-based preventive measures; parents', especially mothers', limited education levels; limited involvement and support from husbands/partners/fathers; as well as limited capacity of health service providers.

Basic causes are pervasive poverty; limited financial resources; limited health infrastructures; and traditional beliefs influencing management of child health. However, successes have been recorded through integrated interventions and coordinated efforts. To keep the pace and sustain the gains in the health sector, the acknowledged strong commitment of the government to reach every Rwandan with health care must be coupled with advanced communication strategic approaches. On the one hand, these approaches will fight and control infectious diseases, prevent and treat communicable diseases, and strengthen prevention and management of non-communicable diseases that impact maternal, infant and child mortality. On the other hand, they will strengthen social and behavior change communication interventions to address behavioral and socio-cultural barriers, as well as equip the population with "facts for life" and key life saving practices as provided for in the 2006 National Behavior Change Communication Policy for Health.

4. KEY PROBLEM BEHAVIORS AND BEHAVIORS TO PROMOTE[10]

4.1 KEY PROBLEM BEHAVIORS TO ADDRESS

This National Social and Behavior Change Communication Sub-Strategy for Maternal, Newborn and Child Health will address the following practices that limit adequate prevention, health care seeking and case management for maternal, newborn and child health:

- Poor reproductive health and poor adoption of preventive measures such as family planning practices, birth timing and spacing of pregnancies, ANC and other health service-seeking behavior including delivering at home and not reporting to the health facility for postnatal or post abortion care.
- Poor recognition of danger signs and home-based care management.
- Poor infant and young child feeding practices, including non-exclusive breastfeeding (giving water with sugar to the newly born baby and water or other liquids to infants under six months, particularly when the child has diarrhea), and inadequate complementary feeding to young children between seven and 24 months.
- Inconsistent use of condom for HIV prevention.
- Poor early testing, diagnosis and treatment of TB.
- Poor hygiene practices such as lack of handwashing practices; feeding the child with unwashed hands; and poor disposal of children's feces, exposing the under-five child to diarrhea.
- Poor room ventilation practice, exposing the newborn and infant to smoke, and low recognition of ARI signs and symptoms, with delays in reporting cases to health facilities and, in most cases, self- and inadequate medication.
- Poor compound and environmental sanitation practices, with stagnant water, weeds and wastage providing breeding sites for mosquitoes, and low use and misuse of LLINs.
- Poor understanding of the importance of reporting cases of physical and SGBV.

4.2 KEY BEHAVIORS TO PROMOTE

- Seek and use reproductive health, family planning, antenatal and postnatal care services including immunization of pregnant women with two doses of tetanus toxoid antigen and of children under one year with all antigens (BCG, DPT3, OPV3, measles and yellow fever); and use of LLINs for children under five and pregnant women.
- Ensure home-based case management practices and timely recognition of the danger signs and symptoms that require immediate referral to a health facility, within 24 hours of manifestation.

[10] For details, see Appendix 1.

- Practice exclusive breastfeeding of the infant up to six months; and introduce appropriate, complementary feeding, while continuing breastfeeding up to 24 months.
- Practice handwashing with soap and water at four critical times.
- Ensure that suspected TB-infected persons and members of their families go for early testing, diagnosis and treatment.
- Clean home compounds; remove stagnant water, weed overgrowth and wastage; and ventilate the home living room to disperse smoke from cooking fires, or use a separate, ventilated cooking area.
- Use youth-friendly VCT services and adopt consistent condom use for HIV primary prevention.
- Report cases of SGBV and seek counseling, post-exposure prophylaxis (PEP) kit, treatment and support for victims.

4.3 KEY MESSAGE CONTENTS: KEY MESSAGE CONTENTS ARE PROPOSED INAPPENDIX1 BY PRIORITY THEME.

5. PARTICIPANT AUDIENCES' ANALYSIS

Analysis of primary, secondary and tertiary audiences for communications

Audience analysis in a communication strategy document answers the following questions:

- Who is supposed to act, to practice the desired behavior to promote? (primary audiences)
- Who influences those who have to take actions? (secondary audiences)
- Which other influential persons or allies could offer support in giving out the information, providing the skills and motivating adoption of the behaviors to promote?(secondary at a second level)
- Who can contribute in helping to reach the particularly "hard-to-reach" audience or reduce particularly stubborn barriers to change, and how? (tertiary audience)

Analysis of audiences enables strategy implementers to highlight the characteristics of the groups to be addressed, to better define how to best reach them, design activities, and choose media and channels that will be most efficient. A thorough analysis also contributes to cost-effectiveness by saving time and resources through channeling communications appropriately to the correct audiences.

Across the practices to be promoted, with the exception of two issues, the primary audiences have been identified as adolescent girls, women of reproductive age, pregnant and lactating women, and mothers and caregivers of infants and young children, and can include other members of the family such as older siblings (male and female), fathers/partners and mothers-in-law. The two issues that are exceptions, with different primary audiences, are:1) home ventilation, which has been identified as the responsibility of husbands and home builders; and 2) health care quality or health care providers.

Husbands/partners were also identified among secondary audiences, together with community health workers and Community Hygiene Committee members, as they exercise influence on the mothers' practices. Also trusted for their advice and the influence they have are health providers, traditional healers, media journalists, and religious leaders, local leaders, civil society organizations and central-level managers.

For the home ventilation practices, men were identified as the primary audience, with officers in charge of environmental health as the secondary audience.

What are the characteristics of these audiences?

Adolescent girls are girls aged 12 to 18. They are found in primary school as well as at the lower secondary education level. They are particularly vulnerable because of large workloads at home, long distances to travel to school, and other barriers to accessing education and health services. They may lack life skills and information on reproductive health. Girls, particularly from poor families, are pressured to have early and unsafe sex by"teachers or traders" in exchange for marks or materials. If targeted with empowering interventions, adolescent girls can change their behavior and

protect their own health and that of their eventual children, as well as serve as models to improved healthy behaviors among the other members of their households.

Mothers are women of childbearing age, many illiterate or with minimal education, living in rural and urban areas. Most of them are poor housewives, farmers or small traders in associations or women's groups. They may have little access to information and services, and limited knowledge of correct child care and preventive practices; or they may lack self-efficacy—defined as the belief that they have the ability to change practices. Mothers often lack community support to negotiate improved practices with their husbands or mothers-in-law. They may adhere to a variety of traditional practices, beliefs and misconceptions, some of which negatively impact the health and development of their children. Mothers belong to religious denominations, either Christian or Muslim, and may access health and nutrition information through their church or mosque. For advice, they refer to and trust their husbands, peers or mothers-in law as well as the CHWs.

Caregivers often are aunts and older sisters. A large percentage of them have little motivation, and little time to take care of the child appropriately while doing other household work.

Husbands are key decision-makers and play an important role in the home. When the child is sick, women ask them for advice, as well as for money to buy drugs or permission to take the child to CHWs or health facilities. Men in rural areas are farmers, livestock keepers and small traders, or earn their living by doing daily labor. Hence they are often away from home. When they have money, men also pass their time in bars, drinking. Men hold all financial powers at home. They are the ones who decide on subscribing to the health scheme "mutuelle," buying food or providing health-related items like LLINs and birth kits for safe delivery. Men are requested to go to ANC with their wives, but often resist.This communication sub-strategy must engage them to support improved health and nutrition behaviors to effect changes in their families. To increase gender equity and reduce gender-based violence, male involvement must be promoted.

Grand-mothers and mothers-in-law are older women, living usually within the extended family. They are influential. They are a source of information on maternal and child care practices, from experience. They mostly resort to herbal medicine to show their powers. Some of these medicines are harmless, but some may have a negative impact on health or delay care-seeking from trained health workers. Young mothers usually refer to their grand-mothers and mothers-in-law for advice, which they trust and follow.

Community health workers are trained and recognized by the health system in Rwanda. Living within the communities, they represent an important secondary audience, because their advice on maternal and child health is trusted and often followed. They are very influential. High-quality, regular supportive supervision can increase their impact by strengthening their skills and standardizing the services they offer. It can also prevent unauthorized practices like demanding payment for their services. Community health workers are given a stipend in-kind, such as a mobile phone to facilitate communication with their clients. They are also trusted with a kit so they can manage cases that are not severe and can assess the severity of the problem and refer to the health facility, if necessary. Comprehensive training on technical content and communication activities, followed by regular supportive

supervision, are proven incentives for improving health worker performance and retention over time.

Community Hygiene Committee members are volunteers based at village level. They are men and women who are empowered to mobilize the community on hygiene practices, facilitate community participation and monitor hygiene-related activities.

Community leaders, religious leaders, youth leaders, youth club members, women's group leaders and leaders of civil society organizations are highly influential. Respected and trusted, they represent an extremely important channel for providing information and motivating adolescents and parents within their community.

Traditional healers and **pharmacists** can usually be found within the community, and they often represent the first line of care when a child is sick, providing herbal treatment and drugs. They are easy to access, though not always less expensive than the health facility. Traditional healers are grouped in associations and are encouraged to work in collaboration with the MoH structures. Pharmacists are found in some urban areas, and the communication strategy should engage them to discourage their customers from self-medication and refer them appropriately to health services. Increased, timely health care seeking will result in more demand for their products, which will benefit everyone.

Police are aknowledgeable and committed body that uses modern technologies to reach the population with awareness messages. A hotline facilitates information processing and data gathering. The police collaborate with hospitals and health centers and have trained staff in counseling, treatment and reintegration of victims of abuse. Because the police are a highly professional and committed body, they are a trusted and reliable source for SGBV case management.

6. COMMUNICATION STRATEGIES, INTERVENTIONS, APPROACHES AND CHANNELS

6.1 COMMUNICATION STRATEGIES

6.1.1 Advocacy

Advocacy is communication targeted at leadership and the powers that take actions to support program objectives. It draws evidence from a combination of data analysis and community inputs from community participation and formative research. In addition, advocacy can stimulate capacity development where lack of skills is a barrier to adoption of the right behavior. In this communication strategy, advocacy will inform and motivate appropriate leaders to create a supportive environment for MNCH through actions such as establishing appropriate policies, allocating resources, speaking out on critical issues such as hygiene and sanitation, and initiating public debate.

6.1.2 Social Mobilization

Social mobilization is a process of harnessing selected partners to raise demand for or sustain progress toward a development objective. This approach engages institutions, community networks, and social and religious groups to use their membership and other resources to strengthen community participation in activities at the grass-roots level.

Social mobilization builds upon data, audience and behavioral analysis, and community inputs. The voice of the community is captured through a consultative process to define mobilization objectives and activities, and to ascertain which stakeholders will have the most influence on the primary participants. In this strategy, social mobilization will be used in health campaigns to build coalitions and ownership among the different stakeholders, adding impact to the interventions and enhancing cost-effectiveness, as there is an opportunity for cost sharing across partners. Attention will be put on coordination mechanisms.

6.1.3 Behavior Change Communication

Behavior change communication is a face-to-face strategy targeting individuals or groups to inform, motivate, problem-solve or plan, with the objective of promoting behavior change. This strategy remains adaptable to the variation in stages of behavior change, tailoring discussions to the participants' current knowledge and practices. It is a highly demanding strategy in terms of human resources if the intervention has to reach a wide coverage. However, modern technology has recently enhanced the scope and reach of such interventions.

6.2 COMMUNICATION INTERVENTION APPROACHES

Given the environment and audience analysis, and based on Rwanda's accomplishments and experience from other African countries, the following six priority communication interventions or approaches are proposed in the SBCC Sub-Strategy for MCHN:

6.2.1 Interpersonal Communication (IPC)

Interpersonal communication is the foundation of all health communication. All health workers, whether in the clinic, hospital orcommunity, rely on person-to-person communication. Interpersonal communication includes individual or group counseling, group meetings, peer education and every day discussions among friends, family members, peers and social networks.

Interpersonal communication plays a crucial role in promoting behavior change because it enables people to discuss new ideas (originating from meetings, social events or through the mass media), ask questions, weigh advantages and disadvantages, and decide whether to act. In addition, people can learn skills, examine influencing factors and discuss strategies to overcome barriers to change, building on information they receive from mass media. It is also vital for effective project design, monitoring and evaluation. The use of interpersonal communication as an approach in this sub-strategy will consider capacity building of the audience participants (family, friends, peers, health workers and leaders). Close supervision, monitoring and coordination will be done to ensure message consistency and quality of each interaction.

6.2.2 Community Mobilization

Community mobilization is a process of bringing together community members in a strategic communication planning process to identify issues, raise awareness of key actors and plan community behavior change activities aimed at a particular health objective. Central to community mobilization interventions is empowerment—the process through which individuals or communities take direct control over their lives and environment. In this sub-strategy, community mobilization will be used to encourage stakeholders' participation and ownership of health programs to sustain change. To achieve results, this sub-strategy will support and integrate ongoing community mobilization activities and leverage support and resources from community structures.

6.2.3 Edutainment

"Edutainment" is any communication initiative that sets out to educate and entertain at the same time. Edutainment is the art of integrating social messages into popular and high-quality communication formats, based on a thorough research process. In this sub-strategy, stories, village dramas, proverbs, radio soap operas, music, radio jingles, songs and competitions have proved effective and will be used to target hard-to-reach audiences and address health issues and barriers that people do not discuss openly.

In Rwanda, edutainment's popularity gives it the advantage of a broad reach; its content is engaging and persuasive in promoting integrated maternal and child health. For example, the interactive, engaging radio soap opera used for health promotion encourages dialogue or reflection by members of the audience; establishes credibility; and sustains interest in and discussion of health issues, ultimately leading to behavior change.

Given the fact that this approach is expensive, this sub-strategy proposes to build an alliance with the Office Rwandaisd'Information (ORINFOR) (Rwanda Information Authority) for easy access to airtime, and with Urunana Development Communication and the Mashirika team, who can act, put on skits or facilitate community theatre. Local teams can also be involved for tailored messages.

6.2.4 Peer Education

Peer education typically involves the use of members of a given group to influence change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs or behaviors. Peer education may also create change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programs and policies.

In Rwanda, social structures are a perfect setting for adopting a peer education approach. Youth groups, children's clubs, women's association or cooperatives, faith-based networks and other organizations offer a good opportunity to engage their audiences and influence behavior change, thus providing support to the mother and adolescent girl. In this sub-strategy, peer education will be used to promote preventive, healthy behaviors through role modeling, and to empower both the educators and their peers, and ultimately the community.

6.2.5 Traditional Communication

There are strategic intervention approaches that should be considered as priority approaches because they have had success in similar cultural environments. Growing evidence shows that in order for health promotion interventions to be meaningful and sustainable in Africa, they must incorporate positive values, knowledge and practices that are part of the culture. Traditional communication channels such as stories, songs and proverbs offer an acceptable way of broaching sensitive topics and may have greater success in promoting behavior change than conventional IEC approaches.

Traditional proverbs have been successfully linked with educational messages on health and development. Being metaphorical, proverbs have many meanings. Through radio shows and village dramas, proverbs are linked with health themes and audiences can add this layer of meaning to their existing store of knowledge. In Rwanda, there are proverbs that can be linked to health messages, such as "Amagara araseseka ntayorwa" or "Akatari amagara barahaha."[11]This message effectively portrays the risk of losing life through unhealthy behaviors.

6.2.6 Social Marketing

Social marketing is an approach that brings to the community the products, behaviors and services related to the health issue being addressed and the behavior being promoted.

Social marketing is based on four Ps: **P**lace, **P**romotion, **P**roduct and **P**rice. The strategy consists of going down to the community with a "multi-package," for instance, using a mobile video unit to reach the targeted community with messages. To reinforce the message, social marketing uses promotional materials such as umbrellas, T-shirts, capsand the like, at an affordable price given the community; products such as condoms are made available after demonstration of use. Songs, animations and skits are used to attract the population.

[11] "Everything can be purchased, except health."

This sub-strategy will use three key engaging strategies in social market interventions:

- *Branding a positive image of the mother and child* through the steps of child survival and development. Through commercial marketing approaches, a healthy image of the mother and child will be introduced. This will help to make available uniform symbols and messages for activities at all levels. This positive image will recall, motivate and help differentiate this concept from other ongoing campaigns. The positive and happy image of mother and child will be used to bring a happy and refreshing perspective to the efforts in saving children's live. This image can easily be portrayed using the Maternal, Infant and Young Child Nutrition Package that has been developed.
- *Branding positive role models for fathers and grand- mothers*: Fathers and grand- mothers are open to new ideas and supporting improved behaviors if they see that support as part of their traditional identities and roles. Communication materials should feature appealing, positive role models to engage men and grand-mothers rather than presenting them as barriers to change.
- *Consistency*: Consistency in messages, interventions and media presence across channels will reinforce messages among audiences, raise awareness of the issue and the improved practices being promoted, and increase the social acceptability of the messages. These effects in turn reduce barriers and increase motivations for adopting improved practices.

6.3 RELEVANT COMMUNICATION CHANNELS FOR RWANDA

Rwanda is a country where people speak the same language, Kinyarwanda. In addition, there is a rich vein of religious culture and music. The woman is the guardian of the child. She bears all the responsibility of the child's welfare, while the husband is supposed to provide mainly financial resources. The grand-mother may help the mother to watch over the child, but does not bear any obligation. Most of the time, women also bear the burden of cultivating the fields or looking after the livestock. They have very little decision-making power.

Husbands are reported to be highly influential in decision-making about child care, with mothers-in-law, grand-mothers, and aunties and sisters influencing child care practices within the household. Most trusted for advice on child care are husbands, mothers-in-law, grand-mothers and CHWs. Local and national leaders also are listened to and highly respected. School teachers, along with religious leaders, opinion leaders and other authority figures, are all perceived as extremely influential in motivating parents to adopt correct maternal and child care practices.

Cultural events and word of mouth: Traditional dances, story-telling, poems and street theater are common channels of communications. Used strategically, word of mouth is the communication channel most likely to reach individuals, families and communities at community gatherings, administrative and religious meetings, and the like, and through one-to-one communication such as peer-to-peer counseling in school clubs or networks, etc.

Today, the culture of reading is spreading even in the rural areas, mainly through literacy interventions. Decentralized structures are well-organized and information networks are being developed. The interfaith networks as well as other community-

based denominations are perfect channels of health communication. The "Rwanda Audience Survey 2009" reports that 72.8% of the population obtains information from church channels. The current SBCC Sub-Strategy will use this opportunity to reinforce IEC in promoting behavior change.

New communication technologies: Recent technological advances have enabled the development of new, exciting approaches to communication. This sub-strategy will build on the advantage of the benefits discussed below and use appropriate technology to reach target audiences.

The community mobile phones are used in health communication, particularly through short message service (SMS), an inexpensive way of obtaining and sharing information. In neighboring Uganda, for example, agricultural cooperatives use SMS to research market price information for agricultural goods. The SMS has been used to support health provision in Iraq, where mothers reported receiving SMS alerts to bring their children to a national polio vaccination campaign in 2005. In South Africa, HIV counselors use cell phones to report on side effects, monitor adherence and provide detailed social information to monitor their clients' well-being. In Rwanda, SMS has been instrumental in monitoring maternal and child health. Reports are sent by the CHWs to the health facility, and information replicated by a central server connected to a network is accessed by health providers and decision-makers at the ministerial level and fosters accountability in health services.

Digital audio players can add impact to peer education as peer educators play recordings that serve as the basis for discussion. Digital players are relatively inexpensive to purchase and maintain. In several projects, digital players are used to promote HIV and AIDS awareness in low-literate communities by providing a platform for open discussion. Digital audio players allow participants to listen to the programs as many times as they want. Digital recorders could also be used to collect feedback and opinionsthat can guide programming and project monitoring.

Health care providers at community health centers and community health workers serve as health promotion structures. CHWs sensitize mothers and communities to adopt healthy practices and to seek quality health care. They also serve as a way to relay key health messages to the community. This sub-strategy proposes to enhance their skills in behavior change communication to have a positive impact on their results.

Mass media, including national and community radio, public as well as private, are equally strong vehicles for communicating health messages. Radio represents the only widespread modern communication channel at national level, and in districts, as the number of private radios is increasing. Radio is particularly powerful when presenting talk shows, radio serial dramas such as "Urunana" or "Umuhoza," and other radio spots.

The population speaks and understands one vernacular language, Kinyarwanda, and the majority has access to radio. The level of radio listenership in both rural and urban areas is high (89.75% listen to radio) at any time of the day.

The introduction of the new technology for communication, TV and mobile phones as well as e-mail, is also adding to the ability to connect and communicate with people. However, due to scarcity of power, access to television is still limited to urban and

peri-urban areas, with viewership varying from 25.6 % to 59.5% at peak evening hours. Hence radio is used to reach the masses.

The monthly community works "Umuganda" or women's or men's cooperatives are powerful channels through which messages are communicated. Of the same importance are youth-friendly centers in which health education is provided to young people through development communication tools and sport for development. These channels offer an opportunity for discussion between boys and girls, and between men and women, leading to adoption of healthy behaviors based on informed choices.

Multiple and sustained community engaging points: Following the multi-channel reach approach, "multiple and sustained community engaging points" will be developed to engage every important and credible source of motivation to facilitate social change around child survival and development. Below is a mix of current and new community outreach efforts to begin and sustain community engagement:

- *Linking of media clubs to "Facts for Life"*: (established in each school)—to involve 20 students and their teacher in one school per district. This initiative can be rolled out after documenting the success of the intervention.
- *Mother care group*—will look after 10–15 families with children under five or pregnant women, and make periodic home visits under the leadership of the village CHW.
- *Mothers' union group*—to bring together 20 mothers in a faith-based group.
- *Community day*—will engage the community through special events or an "open day."
- *Community-based nutrition corner*—will be a prominent place in each village to be set up as a community corner to display community announcements and messages about the nutrition status of children, pregnant women and lactating mothers, etc.

To successfully implement such a comprehensive communication strategy, it is important to prioritize messages and channels of communication so that implementers do not use every medium and channel for every priority behavior. A summary of which types of media and channels are better for which types of messages and behaviors, for primary, secondary and tertiary audiences is proposed below. A sample of a "Creative Brief" to help implementers work with media designers to develop effective behavior change materials with persuasive messages is also presented.

Table 3: Comparison of Media and Materials

MEDIA /MATERIALS	ADVANTAGES	DISADVANTAGES
Interpersonal Communication	▪ Able to provide detailed and tailored information to individuals ▪ Can negotiate small improvements according to individual's willingness and ability ▪ Provides credibility to content ▪ Can do demonstrations, modeling of complex skills ▪ Discusses sensitive, personal topics ▪ Creates support at the communitylevel for new behaviors, ideas, products ▪ Allows for immediate feedback on new content	▪ Time-consuming ▪ Reaches small numbers of individuals ▪ Requires practical skills training ▪ Requires supervision of field workers
Graphics and Print Materials	▪ Provide timely reminders at key spots when and where people need them ▪ Attract attention ▪ Provide basic, standardized information (increase knowledge and raise awareness) ▪ Are handy and reusable ▪ Support interpersonal communication ▪ May be locally produced ▪ Give confidence and credibility to content	▪ May not be cost-effective ▪ Training necessary for proper use and display ▪ (Posters) need to be changed routinely as they can become part of the background
Radio	▪ Reaches many people ▪ Can create demand for a service or product ▪ Provides basic, standardized information (increases knowledge and raises awareness) ▪ Can overcome internal resistance to trying something new ▪ Can improve an image or social norm ▪ Provides timely information ▪ Supports interpersonal communication ▪ May be locally produced ▪ Lends confidence in and credibility to content	▪ Difficult to tailor to specific participant groups ▪ Can be challenging to obtain feedback ▪ Requires access to radio recording equipment or station
TV and Film	▪ Reach many people while providing timely information ▪ Can create demand for a service or product ▪ Can improve an image or social norm ▪ Provide basic, standardized information(increases knowledge and raise awareness) ▪ Can overcome internal resistances to trying something new ▪ Support interpersonal communication ▪ Lend confidence in and credibility to content	▪ Difficult to tailor to specific participant groups ▪ Can be challenging to obtain feedback ▪ Require access to TV station and TV in homes ▪ Costs can be high
Traditional Media and Materials	▪ Use traditionally acceptable forms ▪ Puts new information in a familiar context ▪ Use local talent	▪ Reach small numbers of people ▪ May not be available when needed ▪ Require training and support

Table 4: The Creative Brief

1. **Background**	What is the background of this intervention? Why are you doing it?
2. **Target Audiences**	Whom do you want to reach with your communication? Be specific.
3. **Objectives**	What do you want your target audience to do after they hear, watch or experience this communication?
4. **Obstacles**	What beliefs, cultural practices, pressures and misinformation stand between your audience and the desired objectives?
5. **Key Benefit**	Select one, single benefit that the audience will experience upon reading the objective(s) you have set.
6. **Support Statement Reasons Why**	These are the reasons why the key benefit outweighs the obstacles, and the reasons that what you are promoting is beneficial. These reasons often become messages.
7. **Tone**	What feeling should your communication have? Should it be authoritative, light or emotional? Pick a tone.
8. **Media**	What channel(s) or form will the communication take? Television? Radio? Newspaper? Poster? Point-of-purchase? Flyer? All of the above?
9. **Creative Considerations**	Is there anything else the creative people should know? Will it be in more than one language? Should they make sure that all nationalities are represented?

7. COMUNICATION OBJECTIVES AND EVALUTATION INDICATORS

7.1 THEORETICAL FRAMEWORK

Change theories are a set of **conceptual tools** that allow communication programmers to introduce changes to programs that are not working or to design new ones. They are used **to identify** knowledge, attitudes and norms issues as well as other real or perceived psychological barriers or facilitators to changing individual behavior; **to predict** and **influence** individual behaviors and social change; and to **articulate** which strategies, approaches or tactics will achieve desired program results. Change theories at the design and implementation level will **guide** selection of audience participant groups and **facilitate** segmentation of audiences, such as primary-level audiences for individual change, secondary level for interpersonal-level change and community-level action and at the policy level for policy advocacy. They will **facilitate** selection of communication channels; packaging of the message or the content of the communication; and the development of monitoring and evaluation indicators.

There are three inter-related levels of change theory, defined based on levels of change: Individual-level change, interpersonal-level change and community-level change theories. They complement each other and are used in a coordinated way at different levels of communication: Individual-level theories target change in personal behaviors; the targets for interpersonal-level change theories are social networks; while the target of change for community-level change theories is community development.

The key models behind this SBCC Sub-Strategy for MNCH are the health belief model, the socio-ecological model and the diffusion of innovations model.

The health belief model states that certain cognitive factors—perceived susceptibility to a health threat, perceived severity of contracting an illness or condition, perceived benefit of change, perceived barriers, stimulus to action and self-efficacy—can influence behavior change. **The socio-ecological model** by Bronfenbrenner examines the individual's development within the context of the system of relationships that form his/her environment. This model analyzes the complex layers of environment, each having an effect on the individual's development and the interaction with the larger environment, i.e., the interaction among factors in the child's maturing biology, his immediate family/community environment and the societal landscape that fuels and steers his development.

These two models can be complemented by the **diffusion of innovations model**, which is the process of understanding how new ideas, products and social practices are spread within a community or from one community to another. Diffusion of innovations sees change as an evolution or reinvention of products and behaviors to fit the needs of people. In diffusion of innovations, innovations change, not people. A new idea or innovation typically moves slowly through a societal group as it is first introduced. Obviously, some groups are slower to accept new things than others. Then, as the number of individuals trying the innovation (the adopters) increases, the diffusion of the new idea moves at a faster rate. In communication, this model has the following two advantages:

First, looking at the adoption process, the communication analysis will determine groups that have not adopted the new practices and behaviors. The analysis will focus more precisely on their characteristics, which would include very brief information about: a) communication behavior—whom they speak with, how they get information; b) social status; c) economic status; and d) psychological orientation to society. Analyzing these characteristics will therefore define strategies that will best reach these groups as well as help in the planning of communication inputs that are sympathetic to each of the groups' needs. These inputs include identification of activities, and selection of media and channels that will be most efficient. Second, in terms of saving time, financial and human resources, the analysis will allow for more cost-effective interventions.

The present Social and Behavior Change Communication Sub-Strategy for Maternal, Newborn and Child Health proposes to focus on girls and women in reproductive age as the primary audience who need to adopt the desired behavior. Their partners and husbands also are targeted as direct influencers as well as providers of motivation. Interventions to empower them will be supported by leaders and other decision-makers through advocacy to create a favorable environment for sustainable change and adoption of desired health behaviors. Synergy in interventions will allow for cost-efficiency.

7.2 COMMUNICATION OBJECTIVES AND INDICATORS FOR THE SBCC SUB-STRATEGY FOR MNCH

Presented below are the overall MNCH-related program objectives to which this sub-strategy will contribute, followed by the sub-strategy's communication objectives and their corresponding evaluation indicators.

7.2.1 Overall Health Program Objectives

Following are the14 overall MoH health program objectives to which the SBCC Sub-Strategy for MNCH will contribute over the next three years. These program objectives are outlined under both the *Behavioral Analysis for 6 Priority MNCH Themes* (Appendix 1) and the *Summary of Communication Objectives and Evaluation Indicators for the 6 Priority MNCH Themes*:

- Increase utilization of family planning services from 45% in 2010 to 71% by 2015.
- Reach 100% HPV vaccination for 12–15 girls; and cervical cancer screening in women 30–35.
- Reduce maternal mortality from 476 to 300[12] per 100,000 live births by 2015.
- Reduce neonatal mortality from 27% to 10% by 2015 (the goal was 15% by 2012—EDPRS).
- Increase intake of nutrient-rich foods by pregnant and lactating women.
- Reduce the proportion of children 0–23 months who are stunted.
- Improve personal hygiene habits including those habits that affect disease transmission in children.
- Decrease household factors that affect the environment/sanitation and that increase disease transmission.

[12]MDG target by 2015.

- Contribute to the improved well-being of the Rwandan people through reduction of child morbidity and mortality due to vaccine-preventable diseases.
- Contribute to universal ownership and use of long-lasting insecticide-treated nets (LLINs) for malaria prevention.
- Reduce morbidity and mortality of under-five children from acute respiratory infections.
- Reduce morbidity and mortality in under-five children due to diarrheal diseases.
- Increase demand for health services and improve on health care service quality.
- Increase awareness of the importance of reporting cases of SGBV and seeking support.

7.2.2 Communication Objectives and Evaluation Indicators

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVE	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
1. FAMILY PLANNING, REPRODUCTIVE HEALTH, CERVICAL CANCER					
Overall Objective - Family Planning/Reproductive Health: Increased utilization of FP services from 45% in 2010 to 71% by 2015					
Adolescent girls delay first sexual encounter Sexually active adolescents practice safe sex (i.e., correct and consistent condom use, and secondary virginity)	**Primary Audience**: ▪ Girls 10–14 ▪ Girls 15–19 ▪ Girls 20–24	By the end of 2015, 95 % of adolescent girls 15–24 know key benefits of delaying first sexual encounter Increase knowledge on correct and consistent condom use among youths 15–24 from 58% in 2010 to 80% in 2015 By the end of 2015, 45% of girls with knowledge on correct and consistent condom use adopt this protective method every time they have sex By 2012, 80% of adolescent girls will have increased knowledge on reproductive health and sex education	% of adolescent girls who can express/state at least four benefits of delaying the first sexual encounter % of sexually active adolescents with comprehensive knowledge on correct and consistent use Proportion of sexually active adolescent girls who report consistent correct condom use every time they have sex % of adolescents who received comprehensive knowledge on reproductive health and sex education from secondary audiences	KAP study: need to carry out a quick qualitative survey BSS 2009 Report of training	BSS 2012 DHS 2015
	Secondary Audience: ▪ Parents ▪ Teachers ▪ Sexual partners ▪ Boys 10–14 ▪ Boys 15–19 ▪ Boys 20–24	To increase parent/child communication and among sexual partners of 30 % from estimated baseline by 2015	Proportion of households who allocate time for sex education	Parish reports KAP study	
	Tertiary Audience: ▪ Religious leaders ▪ Civil society organization	By 2015, leaders, religious leaders and civil society organizations are committed to facilitate parent/child dialogue around sex education	# of forums organized # of households reached with message	CSO/FBOs activity reports	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVE	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Women and their partners/husbands plan pregnancies by delaying, spacing and limiting births	**Primary Audience:** ▪ Women 19–24 ▪ Women 25–49	Increase practice of family planning among women of childbearing age to delay, space and limit births from 45% to 75% by 2015	% of women in reproductive age using modern family planning methods	MCH report 2001 DHS 2010	DHS 2015
	Secondary Audience: ▪ Partners/husbands ▪ CHWs ▪ Media	By 2015, husbands and partners support women in childbearing in family planning and agree on a method to use to delay, space and limit births	% of couples using at least one of the modern family planning methods Frequency of radio emission on family planning and shared commitment # of youth circles of dialogue animated	Health center reports HMIS SISCOM	DHS 2015
	Tertiary Audience: ▪ Government authorities ▪ Opinion leaders ▪ Religious leaders ▪ Community leaders	By 2015, opinion leaders, authorities and religious leaders include a message on family planning in their public address	# of advocacy meeting organized on family planning	Partners reports	
Overall Objective - Cervical Cancer: Increase complete HPV vaccination to 100% for all 12–15 girls and screening for cervical cancer for women aged 30–35					
Young girls 12–15 are fully immunized against HPV	**Primary Audience:** ▪ Parents ▪ Guardians (1st primary) ▪ Girls in and out of school aged 12–15 (2nd primary)	By 2015, parents/guardians of girls 12–15 years facilitate them to get fully immunized against HPV By 2015, at least 95% of targeted girls aged 12–15 years are fully vaccinated against HPV	% of parents/guardians facilitating their girls to access the three doses of HPV % of girls aged 12–15 are fully vaccinated against HPV	Report from MoH-MCH, EPI	
	Secondary Audience: ▪ Teachers ▪ School administrators ▪ Media journalists	By 2015, all teachers, schools administrators and journalists mobilize and facilitate girls 12–15 to get fully immunized	Proportion of girls aged 12–15 receiving the three doses # of radios with emission on cervical cancer and HPV	School lists Audience survey Radio calendar	Periodic audience survey on health issues
	Tertiary Audience: ▪ Ministry of Education ▪ MoH ▪ RHCC	By 2015, the Ministry of Health in collaboration with MoH and RHCC will organize advocacy meeting to avail HPV for all women and girls in Rwanda and will sensitize family members to seek for it	# of advocacy meetings organized Percentage of women and girls spontaneously seeking HPV vaccine % of budget allocated to the HPV acquisition	Reports HMIS Budget report	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVE	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
HIV-positive women aged 30–45 years and HIV-negative women aged from 35–45[13] years go for cervical cancer screening	**Primary Audience:** ▪ Women aged 30–35	By end of 2015, at least 50% of HIV-positive women aged up to 30 and HIV-negative women aged up to 35 are aware of the importance of cervical cancer screening	% of HIV-positive women aged up to 30 and HIV-negative women aged up to 35 are aware of the importance of cervical cancer screening	Refer to report on number of women who go for cervical cancer screening	
	Secondary Audience: ▪ Husbands/partners	Increased knowledge of husbands, partners on benefits of cervical cancer screening by 2015	% of husbands, partners explaining importance of cervical cancer screening in women aged 30–45	Quick baseline before and survey after the campaigns	
	Tertiary Audience: ▪ MoH ▪ RBC/RHCC ▪ Development partners	By 2015, the Ministry of Health in collaboration with MoH and RHCC will organize advocacy meeting to available cervical cancer testing kits for all women of reproductive age in Rwanda, and will sensitize women to go for spontaneous screening	# of advocacy meeting organized % of women in reproductive age spontaneously seeking HPV screening, treatment or vaccine % of budget allocated to the HPV acquisition	Health facility reports HMIS Budget report	

[13]MoH strategic plan for cervical cancer.

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVE	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
2. MATERNAL AND NEWBORN HEALTH					
Overall Objective - Maternal Health: Reduce maternal mortality from 476 to 300 per 100,000 live births by 2015 **Overall Objective - Newborn Health: Reduce neonatal mortality from 27% to 10 % by 2015 (the goal was 15% by 2012—EDPRS)**					
Adolescent girls and women who have abortion seek for postabortion care services (PAC) afterwards	**Primary Audience (1):** ▪ Girls aged 10–24 ▪ Women of reproductive age	Increase use of postabortion care services by 2015 Reduce the percentage of women dying from complications due to abortion from 50% in 2006 to 10% by 2015	Proportion of adolescent girls or women who go for PAC services Rate of use of PAC services % of women in reproductive age dying from complications due to abortion	Records from clinics Maternal death audit report and verbal autopsy	What is the current rate of use for postabortion care services?
	Primary Audience (2): ▪ PAC service providers	By 2012, increase the proportion of health providers skilled to provide comprehensive PAC including counseling to girls and women who seek services	Proportion of health providers trained in PAC services # of health facilities delivering PAC according to standards	Training reports HMIS	
	Secondary Audience: ▪ Partners of adolescent girls and women of reproductive age ▪ Parents ▪ MoH/MCH	By 2012, all parents and partners know the danger of abortion and support their adolescent girls/partners to seek postabortion care from a health facility	Proportion of girls/women with four ANC or PAC supported/accompanied	Survey	
	Tertiary Audience: ▪ MIGEPROF ▪ MPs ▪ CSOs	By end of 2015, the Ministry of Gender, The National Women Council and Civil Society Organization organize advocacy meetings to influence to the review of law on abortion	Proportion of meetings held # of laws reviewed/amended	Official gazette MoH report	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVE	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Every pregnant woman attends all four recommended ANC visits before delivery	**Primary Audience:** ▪ Pregnant women	By the end of 2015, increase attendance of the four recommended ANC visits from 35% in 2010 to 80% of all women of childbearing age (15–49) in district of intervention By the end of 2015, 90% of women who miss their period go for pregnancy test immediately and attend the first antenatal visit within the first 3 months of pregnancy	% of pregnant women who attend the four recommended ante natal care visits % of pregnant women in district of intervention attend the first antenatal visit within the first 3 months of pregnancy	MICS KAP study EPI records Health center records EPI records	RDHS 2015
	Secondary Audience: ▪ Husbands/partners ▪ Health care providers ▪ CHWs	By the end of 2015, 80% of husbands/ partners/CHWs in districts of intervention facilitate pregnant women to go for the four recommended antenatal visits starting within the first 3 months of pregnancy	% of pregnant women with four ANC visits supported by either husband/partners or CHWs	RDHS	
	Tertiary Audience: ▪ Religious leaders ▪ CSOs ▪ Women's groups ▪ Local authorities	By the end of 2015, 80% of religious leaders and women associations will have organized advocacy meeting to support all pregnant women who attended the four recommended ANC visits	# of advocacy meetings held with couples # of ambulances by district hospital # of health scheme support to vulnerable couples	Annual reports from CSOs District performance contracts report	
Every pregnant woman recognizes dangers signs and seeks care immediately at a health facility	**Primary Audience (1):** ▪ Pregnant women	Increase the percentage of women delivering in health facility from 69% to 90% by 2015	# of women delivering in health facility Proportion of pregnant women reporting to health facilities with danger signs of pregnancy	RDHS 2010 Health facility records HMIS	
	Primary Audience (2): ▪ Maternal CHWs (ASM)	Increase percentage of maternal CHWs trained in maternal and newborn health, to 100%, by 2015	# of maternal CHWs trained in maternal and newborn health	MoH reports	
	Secondary Audience: ▪ Husbands/partners ▪ Health care providers	By the end of 2015, 90% of husbands, partners and health care providers support pregnant women to deliver in health facility	% of women who report being supported to deliver in a health facility	MoH HMIS	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVE	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
	Tertiary Audience: ▪ Women's groups, local authorities, CSOs, MoH, development partners	By the end of 2015, women's groups, local authorities will advocate for increase of ambulances and maternity wings to support pregnant women willing to deliver in a health facility	# of new maternity wings built # of ambulances # of women delivering in a health facility	HMIS report	
Health care providers should provide quality antenatal, delivery and postnatal care services to all pregnant women and their newborn including special care of the low birth weight infant	**Primary Audience:** ▪ ANC, delivery and PAC service providers	Increase the percentage of women whose delivery is assisted by a skilled birth attendant from 69% to 100% by 2015[14] Increase the % of health care providers trained in MNCH skill set by 2015 Increase the number of service providers who are skilled in IPC of 15% by 2015	% of women whose delivery is assisted by a skilled birth attendant % of health care providers trained in FANC, EMONC, KMC (MNCH skill sets) % of women/caregivers with premature/low birth weight infants using KMC	HMIS Enquête de service du santé, 2007	Further research into quality of care is needed (situation analysis)
	Secondary Audience: ▪ Health care managers	By 2015, health care managers will have increased capacity of health care providers to reach the MNCH quality care standards	# of health providers trained	Health centers human resource development report	
	Tertiary Audience: ▪ MoH ▪ Development partners	By 2015, MoH and its development partners advocate for allocation of resource increment in the health sector to improve skills of health service providers	Proportion of budget increment allocated to health issues	Budget report	

Notes on Quality of Care

Expertise; skills; knowledge; resources

Interpersonal communication (IPC)

Accessibility

Knowledge/expertise/skills

1. ANC:Focused ANC (FANC), HIV Testing—PMTCT;Nutrition/supplements,Malaria in pregnancy (MIP);Danger signs of pregnancy
2. Delivery: Skilled birth attendant
3. PNC: Breastfeeding; low birth weigh/premature)management (KMC and Nutrition

[14]MDG target in 2015.

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
3. MATERNAL NUTRITION, INFANT AND YOUNG CHILD NUTRITION (IYCN); PERSONAL HYGIENE; SANITATION AND ENVIRONMENTAL HEALTH					
Overall Goal - Improve the nutritional status of Rwandan people and appropriately manage cases of malnutrition (underweight, overweight and micronutrient deficiencies) **Overall Objective - Maternal Nutrition: Increase intake of nutrient-rich foods by pregnant and lactating women**					
Pregnant women eat daily an extra meal or a snack that contains food rich in energy, vitamin A or iron Lactating mothers eat daily two extra meals or snacks that contain foods rich in energy, vitamin A or iron Pregnant women receive and take at least 90 iron-folic acid supplements	**Primary Audience:** ▪ Pregnant women ▪ Lactating women	By 2015, a 50% increase in the proportion of pregnant women eating daily an extra meal or snack that contains food rich in energy, vitamin A or iron By 2015, a 50% increase in the proportion of lactating women eating daily two extra meals or snacks that contain energy, vitamin A or iron	% of pregnant women eating daily an extra meal or snack that contain food rich in energy, vitamin A or iron % of lactating women eating daily two extra meals or snacks that contain food rich in energy, vitamin A or iron	KAP surveys with selected communities; exit interviews with mothers at ANC visits	Data gaps: need baseline information Program gaps: are mothers receiving messages about diet in ANC or other contact points (e.g., kitchen garden programs)?
	Secondary Audience: ▪ Husbands/male partners ▪ Family members ▪ Community health workers ▪ Health providers	By 2015, 50% of others in the family and health workers who influence women know key dietary behaviors for pregnant and lactating women and walk them through the adoption of the behaviors	% of husband and family members and CHWs who know key dietary behaviors for pregnant and lactating women % of husbands or family members who increase purchases or availability of foods rich in energy, vitamin A or iron for the family % of CHWs and health workers who are counseling pregnant and lactating women on key dietary behaviors	KAP survey in communities	Data gaps: need baseline information Program gaps: need programs that promote these behaviors in men and families
	Tertiary Audience ▪ Peers ▪ CBOs ▪ FBOs ▪ Local leaders	By 2015, 50% of community members know key dietary behaviors for pregnant and lactating women	% of community members know key dietary behaviors for pregnant and lactating women	KAP surveys in the community	Data gaps: need baseline Program gaps: need programs to promote behavior change in community members

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Overall Objective - IYCN: Reduce the proportion of children 0–23 months who are stunted					
Mothers should exclusively breastfeed for the first 6 months of life (give nothing to the baby but breast milk, no food or other liquids not even water)	**Primary Audience** ▪ Pregnant women, women with children < 6 months	By the end of 2015, the percentage of women exclusively breastfeeding their infants under 6 months of age will have increased from 38% to 60%	% of mothers exclusively breastfeeding their infant under 6 months of age	Baseline: Comprehensive Food Security and Vulnerability Nutrition Survey, 2009 Interviews/KAP study Endline: survey with comparable methodology Observations, interviews (self-reported behavior) Interviews with key informant mothers	Data gaps: RDHS and CFSVNS do not correspond in methodology or findings
	Secondary Audience: ▪ Husbands/male partners ▪ Birth attendants, nurses ▪ Health providers/ midwives, CHWs or maternal community health workers	By the end of 2015, 80% of secondary audience knows the definition and importance of exclusive breastfeeding By the end of 2015, 80% of health providers are counseling pregnant women and mothers of children <6 months on the importance of exclusive breastfeeding and how to exclusively breastfeed and manage breastfeeding problems	% of secondary audience who know the definition and importance of exclusive breastfeeding %of health providers who are counseling pregnant women and mothers of children <6 months on the importance of exclusive breastfeeding and how to exclusively breastfeed and manage breastfeeding problems	Observations, interviews (self-reported behavior), interviews with key informant mothers	Data gaps: baseline information needed
	Tertiary Audience ▪ FBOs, CSOs, Members of Parliaments; National Women's Council; MIGEPROF	By the end of 2015, 80% of tertiary audience knows the definition of exclusive breastfeeding	% of tertiary audience who know the definition of exclusive breastfeeding	Observations, interviews (self-reported behavior), interviews with key informant mothers	Data gaps: baseline information needed

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Mothers practice age appropriate complementary feeding starting at 6 months until 23 months while continuing to breastfeed	**Primary Audience:** ▪ Mothers of children 6–23 months ▪ Caregivers of children 6–23 months	By 2015, 90% of infants are still breastfed by 18–23 months By 2015, a 50% increase in the proportion of children 6–23 months receiving a minimum adequate diet (at least 4/7 food groups and the minimum number of meals per day for their age group)	% of children 6–23 months is receiving a minimum adequate diet	RDHS	Indicatordefinitions : WHO indicators
	Secondary Audience: ▪ Husbands and male partners, family members, peers	By 2012, 80% of husbands, male partners, family members and peers know the definition of a minimum adequate diet for children 6–23 months By 2015, 50% of husbands, male partners, family members and peers buy or grow nutrient-rich foods for children	% of husbands, male partners, family members and peers who know the definition of a minimum adequate diet for children 6–23 months % of husbands, male partners, family members and peers who report regularly buying or growing nutrient-rich foods for children	KAP surveys	
	Tertiary Audience: ▪ CHWs, health workers, FBOs, women's associations, CSOs; Parliamentary Caucus on Social Welfare	By 2012, 80% of tertiary audience knows the definition of a minimum adequate diet for children 6–23 months By 2015, 80% of CHWs and health workers are counseling mothers and caregivers on how to feed a minimum adequate diet to their children 6–23 months and continuing to breastfeed	% of tertiary audience who know the definition of a minimum adequate diet for children 6–23 months % of CHWs and health workers who are counseling mothers and caregivers on how to feed a minimum adequate diet to their children 6–23 months	KAP surveys Facility-based and community health surveys Observations	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Overall Objective - Personal Hygiene: Improve personal hygiene habits including those habits that affect disease transmission in children					
Mothers and caregivers bathe at least once a day, put on washed clothes including underwear every day and clean their teeth twice a day Mothers and caregivers bathe children under 5 at least once a day, put washed clothes on them at least once a day and every time needed, and clean their teeth twice a day	**Primary Audience:** ▪ Mothers of children under 5 ▪ Caregivers of children under 5	A 50% increase in mothers, caregivers and children under 5 who bathe once a day A 50% increase in mothers, caregivers and children under 5 who clean teeth twice aday A 20% increase in mothers and caregivers who put on washed clothes every day A 50% increase in mothers and caregivers who clean the teeth of children twice a day A 75% increase in mothers and caregivers who put washed clothes on their children every day	% of mothers, caregivers and children under 5 who bathe once a day % of mothers, caregivers and children who clean teeth twice a day (or have them cleaned) % of mothers and caregivers who put on washed clothes every day % of mothers and caregivers who bathe children under 5 once a day % of mothers and caregivers who clean the teeth of children twice a day % of mothers and caregivers who put washed clothes on their children every day	Community surveys (KAP) MoH and partners (NGOs). Trials of improved practices for hygiene practices	Data gaps: need a baseline for some of this information Program gaps: need programs to promote these behaviors and need to be sensitive to the capabilities of some families to adopt these behaviors (particularly putting on washed clothes daily)
	Secondary Audience: ▪ Family members, children in schools ▪ Health providers; CHWs ▪ Community Hygiene Committees; PHAST Committees	50% increase in husbands, family members and health workers in communities and facilities who know key personal hygiene practices that mothers and caregivers of children under 5 should be following	% of family members who know key personal hygiene practices that mothers and caregivers of children under 5 should be following	Community surveys (KAPS), MoH and partners	Data gap: baseline data needed Program gaps: programs need to promote these behaviors
	Tertiary Audience: ▪ FBOs, women's associations, CBOs ▪ Local leaders	50% increase in community members who know key personal hygiene practices that mothers and caregivers of children under 5 should be following	% of community members who know key personal hygiene practices that mothers and caregivers of children under 5 should be following	Community surveys (KAPS), MoH and partners	Data gap: baseline data needed Program gaps: programs need to promote these behaviors

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
All mothers/caregivers wash their hands with soap or ashes after contact with excreta (including after cleaning up after babies) and before preparing food All mothers/caregivers wash their hands and children's hands with soap or ashes before feeding the child	**Primary Audience:** ▪ Mothers of children under 5 ▪ Caregivers of children under 5	By the end of 2015, 50% of all mothers/caregivers wash their hands with soap or ashes after contact with excreta (including after cleaning up after babies) and before preparing food By the end of 2015, 50% of all the mothers/caregivers wash their hands and children's hands before feeding the child	% of mothers/caregivers wash their hands with soap or ashes before preparing food % of mothers/caregiver washes their hands and their child's hand with soap or ashes before feeding their child	Interviews/KAP study. Observations in homes, self-reported behavior	Data gap: baseline data needed Program gaps: programs need to promote these behaviors
	Secondary Audience: ▪ Husbands/fathers ▪ Family members ▪ Children in schools ▪ CHWs, health workers	By the end of 2015, 50% of all husbands/fathers and other family members know key handwashing behaviors that mothers/caregivers of children under 5 should be following By the end of 2015, 50% of all health workers and CHW know key handwashing behaviors that mothers/caregivers of children under 5 should be following By the end of 2015, 90% of all health workers and CHWs counsel mothers and caregivers of children under 5 on key handwashing behaviors	% of husbands/fathers and other family members who know key handwashing behaviors that mothers/ caregivers of children under 5 should be following % of health workers and CHW who know key handwashing behaviors that mothers/ caregivers of children under 5 should be following % of health workers and CHW who counsel mothers and caregivers of children under 5 on key handwashing behaviors	Interviews/KAP study Observations Interviews/KAP (self-reported behavior)	Data gap: baseline data needed Program gaps: programs need to promote these behaviors
	Tertiary Audience: ▪ PHAST Committees, FBOs, women's associations, CBOs ▪ Local leaders	By the end of 2015, 90% of all community members know key handwashing behaviors that mothers/caregivers of children under 5 should be following	% of community members who know key handwashing behaviors that mothers/ caregivers of children under 5 should be following	Interviews/KAP study Observations Interviews/KAP (self-reported behavior)	Data gap: baseline data needed Program gaps: programs need to promote these behaviors

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Overall Objective - Sanitation and Environment Health: Decrease household factors that affect the environment/sanitation and that increase disease transmission					
Each family member disposes all feces, including children's, in a safe, hygienic latrine	**Primary Audience:** ▪ All family members	By 2015, a 50% increase in the proportion of families dispose all feces, including children's, in latrines with cover	% of all family members dispose of feces, including children's, in latrines with cover	KAP surveys, CHWs and villages' administrative authorities	DHS 2015
	Secondary Audience: ▪ CHWs, health providers, teachers; PHAST committees/ Community Hygiene Committees	By 2015, a 50% of community health workers and health workers and other educating on sanitation are giving key messages about feces disposal	% of health educators giving key messages about feces disposal	KAP surveys, CHWs and villages' administrative authorities	
	Tertiary Audience: ▪ Community leaders ▪ Administrative authority ▪ FBOs, CBOs	50% of community leader (administrative, FBOs and CBOs) know key messages about feces disposal By 2015, 40% of community leader (administrative, FBOs and CBOs) hold advocacy meetings on importance having hygienic latrines and use them properly to avoid incidence of diarrhea in children under 5	% of community leaders (administrative, FBOs and CBOs) know key messages about feces disposal # of households using hygienic latrines # of incidence cases of diarrhea in children under 5	KAP surveys, CHWs and villages' administrative authorities Health center reports	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Families ventilate their homes	**PrimaryAudience:** ▪ Fathers/mothers	By end of 2015, 25% of houses will have either a ventilated living room (defined as provided with large window that can be opened or other system of smoke evacuation) or a separate room (kitchen) with ventilation for cooking purposes	% of houses in districts of intervention with a ventilated living room or separate kitchen with ventilation for cooking purposes	Interviews/KAP study Observations during house-to-house survey	Environmental Health Survey
	Secondary Audience: ▪ Family members ▪ Community leaders FBOs, builders of homes	By end of 2015, 75% of family members, community leaders, FBOs, builders of homes know how a home should be ventilated to avoid over-exposure to smoke By end of 2015, 30% of builders are building homes with adequate ventilation	% of family members, community leaders, FBOs, builders of homes who know how a home should be ventilated to avoid over-exposure to smoke % of builders who are building homes with adequate ventilation	Interviews/KAP study Observations during house-to-house survey	
	Tertiary Audience: ▪ District environmental health officer ▪ Technology innovators	By end of 2015, 75% of district environmental health officers, technology innovators know how a home should be ventilated to avoid over-exposure to smoke and advocate for new smoke-free stove	% of district environmental health officers, technology innovators who know how a home should be ventilated to avoid over-exposure to smoke # of households with smoke-free stoves	Interviews/KAP study Observations during house-to-house survey	
Families regularly clear mosquito-breeding sites around houses	**PrimaryAudience:** ▪ Fathers/mothers	By the end of 2015, 50% of households will clean their compound on a daily basis defined as removal/drainage of stagnant water, cutting of weeds around the house and wastage disposal in compost fence	% of households with clean compound, as per above definition	Interviews/KAP study Observations during house-to-house survey	
	Secondary Audience: ▪ Members of the family ▪ CHWs and health workers	By the end of 2015, 80% of family members and CHWs and health workers will know the methods for keeping compounds free of mosquitoes	% of family members and CHWs and health workers who know the methods for keeping compounds free of mosquitoes	Interviews/KAP study Observations during house-to-house survey	
	Tertiary Audience: ▪ Community leaders ▪ District environmental health officers	By the end of 2015, 80% of community leaders and district environmental health officers will know the methods for keeping compounds free of mosquitoes and advocate for adoption of practices	% of community leaders and district environmental health officers will know the methods for keeping compounds free of mosquitoes	Interviews/KAP study Observations during house-to-house surveys	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Families keep domestic animals in a pen away from living and cooking spaces	**Primary Audience:** ▪ Husbands and wives	By the end of 2012, 30% of households will keep animals in a pen away from living and cooking spaces	% of households that keep animals in a pen away from living and cooking spaces	Observations during house-to-house surveys	IECV
	Secondary Audience: ▪ Members of the family ▪ CHWs and health workers	By the end of 2012, 80% of family members and CHWs and health workers know two benefits of keeping animals in a pen away from living and cooking spaces	% of family members, CHWs and health workers who know two benefits of keeping animals in a pen away from living and cooking spaces	Observations during house-to-house surveys	
	Tertiary Audience: ▪ Community leaders ▪ District environmental health officer ▪ Opinion leaders ▪ Women's and youth structures	By the end of 2012, 80% of community leaders, district environmental health officers, opinion leaders, women and youth structures know two benefits of keeping animals in a pen away from living and cooking spaces and sensitize population to build pens for domestic animals in every household	% of community leaders, district environmental health officers, opinion leaders, women and youth structures who know two benefits of keeping animals in a pen away from living and cooking spaces # of households with separate animal pens	Observations during house- to-house surveys	
4. COMMUNITY AND FACILITY IMCI, EPI (INCLUDING VITAMIN A AND DE-WORMING), MALARIA, ARIs, DIARRHEA					
Overall Objective - EPI: To contribute to the improved well-being of the Rwandan people through reduction of child morbidity and mortality due to vaccine preventable diseases (Source: EPI Strategic Plan)					
Mothers and caregivers of children under 5 take all eligible children for all scheduled immunization including vitamin A and de-worming	**Primary Audience:** ▪ Parents and caregivers of children under 5	By the end of 2012, 95% of parents and caregivers of children under 5 in districts of interventions who know the benefits, schedule, vaccines and other interventions (vitamin A, de-worming) By the end of 2015, 96% of all eligible children who have received all scheduled immunizations including 2 doses of rotavirus from birth up to 9 months	% of parents/caregivers of children under 5 able to correctly state the benefits of immunization, schedule of immunization, and name of at least three diseases prevented by the vaccines % of fully immunized children at age one year	EPI data; KAP study Health center records EPI data	DHS 2015
	Secondary Audience: ▪ CHWs, relatives (grandmothers, mothers-in-law)	By the end of 2012, increase the knowledge of CHWs and relatives in districts of interventions to support parents to take their children to immunization (vitamin A, de-worming)	# of CHW s trained in counseling parents/relatives # of parents who take children to be fully immunized	Report of training Health center data SISCOM	RDHS 2015

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
	Tertiary Audience: ▪ CSOs, FBOs ▪ Community leaders	By the end of 2012, CSOs/FBOs support to the immunization program will be increased by 25% (from where it stands now).	# of health interventions by CSOs/FBOs in support to immunization program # of meetings organized for mother's groups	EPI report Stakeholders' mapping report	
Overall Object - Malaria: Universal ownership and use of long-lasting insecticide-treated nets (LLINS) for malaria prevention (Source: HSSPII 2009–2012)					
Every child under 5 and all pregnant women sleep under LLINs every night	**Primary Audience:** ▪ Parents of children under 5 ▪ Pregnant women	By end of 2012, 96 % of parents in districts of intervention know the benefits of sleeping under a LLIN every night especially for pregnant women and children under 5 By the end of 2015, children under 5 sleeping under LLIN every night will increase by 20% (from 70%; DHS 2010) By end 2015 of pregnant women sleeping under LLIN every night will increase by 15% (from 80%; DHS 2010)	Proportion of parents of children under 5 able to state at least two benefits of sleeping under LLIN every nights, know how to hang LLIN Proportion of children under 5 sleeping under LLIN every night Proportion of pregnant women sleeping under LLIN every night	Periodicstudies (MIS) RDHS 2015	RDHS 2015
	SecondaryAudience: ▪ CHWs	By end of 2012, CHWs understand the importance of home visits to monitor the use LLTNs and will increase of 25% from 69%	# of families properly using LLINs	CHWs' home visitreports	KAP study
	Tertiary Audience: ▪ Community leaders ▪ Health providers	By 2012, relevant religious, social and community groups discuss at regular meetings consistent use of LLINs by pregnant women and children under 5 to prevent against malaria	# of meetings organized by community leaders # ofLLINsdistributed	Health center report	District report
Mothers/caregivers of children under 5 seek appropriate care and treatment for a child with fever	**Primary Audience:** ▪ Mothers of children under 5 ▪ Fathers of children under 5 ▪ Caregivers of children under 5	By the end of 2012, 85 % of mothers/fathers/caregivers of children under 5 in districts of interventions have increased knowledge on the importance of seeking care for a child under 5 with a fever By the end of 2015, 75% of mothers/ fathers/caregivers of children under 5 in districts of interventions seek appropriate treatment for children under 5 with fever (from 43%; Source: RDHS 2010)	Proportion of mothers/fathers/ caregivers who state correctly the importance of seeking care and treatment for a child under 5 with a fever Proportion of mothers/fathers/caregivers who seek treatment for their child under 5 with a fever	SISCOM RDHS 2015	RDHS 2015

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
	Secondary Audience: ▪ Family members (grandmothers, mothers-in-law) ▪ CHWs ▪ Leaders of FBO	By the end of 2012, increase the knowledge of CHWs and relatives of parents of children under 5 in districts of interventions on the importance of early care and treatment of children with fever	# of CHWs trained in case management # of children under 5 with fever cases referred to health centers	Training report HMIS, health center report	SISCOM
	Tertiary Audience: ▪ CSOs ▪ Community and opinion leaders ▪ Traditional healers ▪ Health providers ▪ Local authorities	Through advocacy by selected CSOs, community leaders, all mothers/caregivers of children under 5 in districts of interventions access appropriate treatment for children with fever	# of children taken for treatment # of children who received treatment for fever	Health center report	HMIS
Overall Objective - ARIs: Reduce morbidity and mortality of children under 5 from acute respiratory infections (ARIs) (Source: IMCI strategic plan)					
Mothers/caregivers recognize signs of ARIs and seek appropriate care for children under 5 with ARIs	**Primary Audience:** ▪ Mothers of children under 5 ▪ Caregivers of children under 5	By the end of 2012, at least 80% of mothers/caregivers of under 5 children in districts of interventions recognize danger signs ofARIs in their children By the end of 2012, 80% of mothers/ caregivers of children under 5 in districts of interventions have increased knowledge on the importance of seeking care for a child under 5 with signs of ARIs By the end of 2015, 75% of mothers/caregivers in districts of interventions seek appropriate treatment for their children under 5 with signs of ARIs (from 50%;Source: DHS 2010)	# of mothers, caregivers of children under 5 who recognize danger signs of ARIs increase by 20% Proportion of mothers/ caregivers who can state at least two danger signs of ARI Proportion of mothers/ caregivers who state correctly the importance of seeking care and treatment for their child under 5 with signs of ARIs Proportion of mothers/caregivers who seek treatment for their child under 5 with signs of ARI	RDHS 2015 KAP study Health center report	RDHS 2015
	Secondary Audience: ▪ Fathers ▪ Grandmothers ▪ CHWs	By the end of 2012, increase the capacity of CHWs in districts of interventions to detect ARIs in under 5 by recognizing danger signs and referring cases for management	# of cases detected by CHWs and referred to health center	Health center reports SISCOM	HMIS

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
	Tertiary Audience: ▪ FBOs ▪ Community leaders ▪ Traditional healers	By 2012, all traditional healers are sensitized on the importance of respectingMoH policy on children under 5 ARIs case management by qualified health providers	# of advocacy meetings by FBOs and community leaders	Reports (District or Health Center)	
Mothers/caregivers of children under 5 complete prescribed treatment for all illnesses	**Primary Audience:** ▪ Mothers/caregivers of children under 5	By the end of 2012, 85% of mothers/ caregivers of under 5 children in districts of interventions have increased knowledge on the importance of completing prescribed treatment for sick children under 5 By the end of 2012, 75% of mothers/ caregivers of children under 5 in districts of interventions complete prescribed treatment every time an under-5 child is sick	Proportion of mothers/ caregivers who state correctly the importance of completing prescribed treatment for their sick children under 5 Proportion of children under 5 on medication who complete treatment	Periodic studies Health center report	DHS 2015
	Secondary Audience: ▪ Fathers, family members ▪ CHWs	By the end of 2012, each CHW in the district of intervention will have increased skills to counsel a mothers of children under 5 and monitor their compliance with medical prescription	Proportion of mothers reporting regular monitor by CHWs	SISCOM	
	TertiaryAudience: ▪ FBOs ▪ Media journalists	By 2012, religious leaders, community radio presenters engage mothers and other stakeholders in community dialogue on child health and the importance of completing prescribed treatment for all children under 5	# of meetings organized by FBOs to mobilize mothers on the importance of quality care and completing prescribed treatment for children under 5 # of child health-related radio emissions per month	Reports Audience survey	Media reports

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Diarrhea Overall Objective - To reduce morbidity and mortality in children under 5 due to diarrheal diseases (Source: IMCI Strategic Plan)					
Mothers/caregivers of children recognize signs of diarrhea, manage it with ORS and appropriate recommended fluids and treatment	**Primary Audience:** ▪ Mothers, caregivers of children under 5	By the end of 2012, at least 80% of mothers/caregivers of children under 5 in districts of interventions recognize danger signs of diarrheas in their children and manage it with ORS and other fluids including breasfeeding By the end of 2012, 80% of mothers/ caregivers of children under 5 in districts of interventions have increased knowledge ontheimportance of seeking care for all children under 5 with diarrhea By the end of 2015, % of mothers/caregivers in districts of interventions who seek appropriate treatment for their children under 5 with signs of diarrhea increase of 20%	# of mothers/caregivers of children under 5 who recognize danger signs of diarrhea increase by 20% Proportion of mothers/ caregivers who state correctly the danger signs of diarrhea for a child under 5 Proportion of mothers/ caregivers who state importance giving recommended fluids to their child under 5 with diarrhea Proportion of mothers/ caregivers know the importance of seeking treatment for their child under 5 with signs of diarrhea Proportion of mothers/ caregivers who seek treatment for their child under 5 with signs of diarrhea	KAP study Health Center report	DHS 2015
	Secondary Audience: ▪ Fathers, family members ▪ CHWs	By end of 2015, family members and community health workers have increased knowledge to support mothers in home management of diarrhea cases of their children under 5	# of members of families trained in home management of diarrhea # of cases managed by CHWs	SISCOM	DHS 2015
	Tertiary Audience: ▪ FBOs ▪ Community leaders	By 2012, religious leaders and community leaders engage mothers and caregivers in dialogue on child health and the importance of proper management and treatment of diarrhea cases for all children under 5	# of meetings organized by FBOs to sensitize mothers and caregivers on the importance of quality management and treatment of diarrhea for children under 5	FBOs'reports	DJAF reports

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Mothers/caregivers of children under 5 suffering from diarrhea seek appropriate care from health providers without delay	**Primary Audience:** ▪ Mothers/caregivers of children under 5	By the end of 2015, 75% of mothers/ caregivers in districts of interventions whose children have diarrhea seek appropriate treatment for their under-5 children with diarrhea without delay (denominator missing)	Proportion of mothers/ caregivers who immediately seek treatment for their child under 5 with diarrhea	Health center report SISCOM	
	Secondary Audience: ▪ Fathers, family members ▪ CHWs ▪ Health providers	By end of 2015, family members and community health workers have are capable of detecting severe cases of diarrhea in their children under 5 and refer them to the health facility for appropriate treatment	# of CHWs trained in diarrhea home management # of cases of children under 5 with severe diarrhea referred to health facility for appropriate care	SISCOM Training report	
	Tertiary Audience: ▪ Community leaders ▪ Women's council representatives	By 2015, all community leaders and women council representatives in district of intervention hold advocacy campaigns for parents and caregivers to seek appropriate treatment without delay every time their child under 5 has a severe case of diarrhea	# of advocacy campaigns held targeting both parents and caregivers on severe diarrhea case management # of severe case reported subsequent to sensitization	Community development plan report Health center report	HMIS
Mothers/caregivers continue appropriate feeding for children with diarrhea or other illness or who recovers from diarrhea and/or illness.	**Primary Audience:** ▪ Mothers/caregivers of children under 5	By the end of 2012, 85% of mothers/ caregivers of children under 5 in districts of interventions have increased knowledge on the importance of continuous appropriate feeding of children under 5 suffering from diarrhea By the end of 2015, 75% of mothers/ caregivers of children under 5 in districts of interventions continue to feed their children while continuing to administer the prescribed treatment	Proportion of mothers/ caregivers who state correctly the importance of continuous feeding of children under 5 suffering from diarrhea Proportion of mothers/ caregivers who continue feeding their children under treatment	KAP Report from the health center	
	Secondary Audience: ▪ Family members, CHWs Traditional healers	By end of 2015, family members, CHWs and traditional healers are capable to advise mothers to prepare nutritious food for children under 5 suffering from diarrhea By 2015, an increasing number of traditional healers are oriented to importance of nutrition and treatment of children with diarrhea	# of mothers, fathers and CHWs with knowledge of what is nutritious for a young child suffering or recovering from diarrhea or other sickness # of referrals a traditional healer makes for children with diarrhea to the health facility or the CHW	Training reports Family members, Traditional healers testimonies Health center or CHW reports	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
5. HIV AND AIDS, OTHER STIs AND TUBERCULOSIS (TB)					
HIV/AIDS, Other STIs Objective: HIV incidence is reduced significantly and STIs treated					
HIV discordant couples use condom for every sexual contact (2.2% of heterosexual couples are HIV sero-discordant–around 60,000 couples)	**Primary Audience:** ▪ HIV discordant couples	By 2015, 60% of discordant couples will have increased knowledge on importance of consistent condom use to reduce HIV risk for their partners	# of couples who receive testing and counseling together % of discordant couples that remain discordant after 6 month period enrolment to couples' testing and counseling Proportion of discordant people reporting consistent condom use	Sentinel Surveillance Data at ANC from health facilities BSS	BSS
	Secondary Audience: ▪ CHWs, health providers	By 2015, 80% of health providers and community health workers increase knowledge on the importance of regular follow up and quality care to discordant couples and mentor them	# of couples regularly mentored and supported by CHWs	Health facility reports	BSS
	Tertiary Audience: ▪ FBO, leaders/ authorities at respective levels, CHWs	By 2015, 60% of stakeholders at community level have increased their support to investment in specific programs targeting discordant couples	# of programs/project targeting discordant couples	JDAF progress reports CDLS reports	Programmatic response for a subpopulation of concern report
Sexually active couples with symptoms of STIs seek screening/medical care together and adhere to regimen	**Primary Audience:** ▪ Couples	By 2015, 80% of coupleshave increased knowledge of the symptoms of STIs and importance of screening for STIs and treatment By 2015, 75% seekmedical treatment together By 2015, the number of discordant couples who go for regular STI screening and complete prescribed treatment will have increased of 40%	% of couples reporting symptoms of STIs and importance of screening for STIs and treatment # of couples seeking screening together # of couples seeking treatment from clinical services together # of discordant couples reporting to health facility for STIs checkup # of patients with STI who report completing treatment	NSP, IHDPC-HIV Division Health facility data report	BSS

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
	Secondary Audience: ▪ Peers, sexual partners ▪ Parents ▪ VCT health providers for HIV and STIs	By 2015, 80% of men and women in associations, sexual partners, and health providers will have increased knowledge of their roles to support couples with symptoms of STIs to complete treatment	# of couples mentored by VCT health providers Proportion of reversed trend of new STIs infection	PBF reports Surveys VCT reports	Programmatic response for a specific subpopulation of concern report
	Tertiary Audience: ▪ Community leaders ▪ Leaders of FBOs ▪ Health providers	By 2015, 80% of community and FBO leaders and health providers advocate to avail VCT services at community reach and stigma reduction	# of VCT mechanism set up at community reach	CDLS report	Programmatic response report
Tuberculosis (TB) Objective: Decrease TB infection and prevalence rate by 50% by the year 2015					
Persons with a cough which lasts 2 weeks or more and members of their families test for TB	**Primary Audience:** ▪ Parents and caregivers of children under 5	To increase knowledge of70% of parents and caregivers of children under 5 on the signs of TB and benefits of early testing by 2012 To increase the percentage of persons with cough testing for TB from 60% to 70% by 2015	% of parents and caregivers of children under 5 able to mention at least 4 signs of TB TB detection rate	TB NSP ME PLAN 2009–2012 TB STRATEGY 2009–2012 TB M&E report DHS 2015	Primary survey will be done end of 2012
	Secondary Audience: ▪ Family members ▪ Community members	To increase knowledge of 70% of family and community members on the signs of TB by 2012 To increase of 16% the proportion of family members who encourage their relatives with suspected cough to test for TB by 2015	% of family members who correctly state all signs of TB # of sessions on TB held for family and community members # of communication aid material received by family and community members proportion of TB suspect persons accompanied by a relative to test for TB	Health care service exit interview Surveys	Programmatic response report
	Tertiary Audience: ▪ Leaders/authorities at respective levels, CHWs	By 2015, 80% of local authorities and CHWs talk about the risk of TB at Umuganda and other public events	# of events organized in which people are called for testing for TB	Report of meeting	

BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION OBJECTIVES	EVALUATION INDICATORS	DATA SOURCE	DATA GAPS
Household members infected with TB complete prescribed dose of treatment and practice all recommended preventive behaviors (hygiene, nutrition)	**Primary Audience:** ▪ Parents and caregivers of children under 5	By 2015, increase by 87% the percentage of family members infected with TB who complete prescribed dose of treatment and observe all recommended preventive behaviors	TB treatment rate # of TB infected patients who report completing prescribed dose and observing recommended preventive behaviors	TB NSP M&E PLAN 2009–2012 TB STRATEGY 2009–2012 Health service exit interviews	Programmatic response report
	Secondary Audience: ▪ Mothers-in-law, household members, community members, CHWs	By 2015, 75% of family members support their TB infected relative on treatment and observe recommended behaviors	# TB infected patients who report support from family members in completing prescribed dose and observing recommended preventive behaviors	Health service exit interviews	Programmatic response report
	Tertiary Audience: ▪ Leaders/authorities	By 2015, all leaders and local authorities sensitize people on TB treatment to complete the prescription and observe recommended preventive behaviors	# of community events organized by local leaders # of addresses targeting TB prevention and treatment	Reports from the decentralized level	
6. SEXUAL AND GENDER-BASED VIOLENCE (SGBV)					
Overall Objective: To increase awareness on importance of reporting cases of SGBV and seeking support					
Every abused woman or girl reports the abuse / rape and go for comprehensive care (testing, PEP, ECP), counseling, treatment, psycho- social and legal support as well as reintegration	**Primary Audience:** ▪ Girls 10–18 ▪ Women aged 19 and above	By 2015, all survivors of SGBV report cases of abuse through the hotline 3512 and report to the one-stop center	#of reported cases to the hotline and one-stop center	One-stop center records	GBV assessment report from the police or local governance
	Secondary Audience: ▪ Male sexual partners, parents, relatives	By 2012, parents of children victims of abuse report cases to the police By 2012, parents are aware of the one-stop center and seek counseling and care	# of cases reported to the police by parents, male sexual partners or relatives # girls/women/men who receive comprehensive care in one-stop center	Police report One-stop center data	GBV assessment report from the police or local governance National survey on SGBV
	Tertiary Audience: ▪ Leaders/authorities at respective levels, women's associations ▪ National police	By 2015, all stakeholders at national and district levels have organized advocacy campaigns against SGBV	# of campaigns held by stakeholders at different levels #and type of cases reported following the advocacy campaign # of cases addressed	Stakeholders' reports	MIGEPROF programmatic response report

8. STRATEGIC COMMUNICATION PLAN

STRATEGIC PHASES	ACTIVITIES	ACTIVITY OBJECTIVES	MONITORING INDICATORS	MEANS OF VERIFICATION
Strategic Phase 1				
Validation, reproduction, dissemination of and advocacy for the SBCC Sub-Strategy for MNCH	Validation and approval of the SBCC for MNCH Sub-Strategy by MoH and participating stakeholders	To gain the endorsement by the MoH and expressions of support for the SBCC for MNCH Sub-Strategy from key participating stakeholders To ensure that official communications are sent to relevant district managers, directors of MNCH programs, and heads of agencies by the MoH	SBCC Sub-Strategy endorsed by MoH # of communications sent to district managers, directors of MNCH programs, and heads of agencies by the Minister of Health	Minutes/report of the validation meeting
	Reproduction and dissemination of the SBCCSub-Strategy for MNCH	To finalize the layout of the sub-strategy, determine the number of copies required, identify printer, and print To provide key stakeholders at national and district- levels with a copy of the sub-strategy, to guide their planning for communication interventions to support MNCH initiatives	Number of copies printed Number of copies disseminated with recipients indicated	Verification of print run Activity report from MoH
	Organize partnership building meetings at the national and district-levels to: ▪ Orient key stakeholders ▪ Identify opportunities ▪ Design a roadmap ▪ Establish coordination mechanisms ▪ Create an M&E Task Force	To secure commitment of various partners to agree on: roles, complementarity and accountability among partners;implementation roadmap for joint interventions To establish SBCC for MNCH Monitoring and Evaluation Task Force	Attendance at partnership meeting A roadmap agreed on Monitoring task force set up	Action plan, progress reports, joint monitoring reports
	Hold advocacy meetings with religious leaders–one national-level and one in each focus district	To build alliances with religious leaders for inclusion of MNCH related messages in their activities	# of meetings held	Meeting reports
	Design and organize partners' orientation workshops for members of interfaith, media, and other community-oriented organizations to share the strategy, reinforce the importance of SBCC for MNCH and secure collaboration	Increase awareness on health issues and uptake of proposed community-level activities	# of orientation workshops held	Workshop reports

STRATEGIC PHASES	ACTIVITIES	ACTIVITY OBJECTIVES	MONITORING INDICATORS	MEANS OF VERIFICATION
Strategic Phase 2				
Review of existing communication and training materials, update/adaptation of existing materials and/or development of new materials where needed	Organize a series of workshops to review existing communication tools/materials/ messages based on the SBCC Sub-Strategy Develop new tools/materials/messages and/or update/adapt existing ones	To review, harmonize and update and/or develop communication materials and messages	# and type of integrated communication materials developed and distributed # of communication materials updated	Updated communication materials Reports
	Reproduce existing (if appropriate) and/or new communication materials	Avail or (encourage) use the same communication material to all stakeholders in communication activities	# and type of new communication materials developed per subject area	Harmonized communication package Reports
	Develop, test, and reproduce SBCC for MNCH-focused TOT and participant materials for CHWs, women, religious and youth leaders, community mobilization facilitators and other key change agents	Avail SBCC for MNCH-focused training materials to all key partners for training of key change agents	# and type of training materials produced	SBCC training package Reports
	Develop training materials on SBCC for MNCH for community mobilization facilitators	Avail SBCC for MNCH specifically for community mobilization facilitators	# of training manuals Report of the process is available	SBCC training package reports
	Conduct one TOT workshop on behavior change communication skills and facilitating community dialogue	Constitute a core team of TOT facilitators at national level	One workshop held; one national-level core TOT evaluation report	Training reports
	Conduct TOT session for community health workers, volunteers, religious, women, men and youth leaders, environmental health workers, on maternal, newborn and child health promotion practices at district level	Constitute a core team of community facilitators on dialoguing around the MNCH behaviors to promote Empower teachers and young people in school media clubs to become facilitators of young adolescents in schools and “captains and coaches” around schools for RH and FP	One functioning core community facilitators team	Review action plans per district

STRATEGIC PHASES	ACTIVITIES	ACTIVITY OBJECTIVES	MONITORING INDICATORS	MEANS OF VERIFICATION
Strategic Phase 3				
Management, implementation, and routine monitoring	Support training ofcommunity radios broadcaster in district of interventions in SBCC and key MNCH behaviors to promote through facilitating school-based dialogue on MNCH themes	Engage school-based media clubs and community radio in dialogue on MNCH	# of radio talk show programs on MNCH per week/month # of recorded emissions	Reports of intercept interviews with listeners
	Organize one national-level and 5 province-level trainings and production workshop for radio broadcasters and editors	Involve print, audio and online journalists in MNCH issues Produce quality content and agreed on messages for media dissemination	# of MNCH focused audio and print materials produced and disseminated per year	Media reports
	Ensure CHW and volunteer capacity building on communicating health messages	Harmonize messages taken to the mother in all districts of intervention Ensure quality of interventions	# of workshops held for CHWs/ community volunteers, etc. in district of interventions # of workshop reports	Workshop reports
	Develop outline on MNCH themes for inclusion within media clubs debates	Provide theme outlines and facilitators' orientation on debate methodology	# of debate with a logical flow of session	Debate reports
	Organize TOT and training workshops on key practices targeting teachers and how to provide life skills training to children	To provide teachers with counseling skills to support adolescent girls deal with pressure	# of teachers with adequate skills Training report evaluation sheet	Workshop reports
	Support planning process on MNCH in identified zones	Ensure quality of community-based action plans	# of quality plans by community	Communication action plans
	Support community dialogue initiatives using multi-channels	Empower and involve communities in MNCH promotional activities	# of community initiatives, meetings held	Interviews, reports on key issues, tackles
	Support development and broadcast of radio spots and programs	Reinforce messages provided by CHWs through interpersonal communication	# and quality of messages for IPC # of radio spots on MNCH	Interviews Radio programs
	Support organization of content production workshop for drama groups	Ensure quality of messages	# and quality of messages # of issues tackled in drama content	Exit interviews
	Support drama groups performances	Create awareness on MNCH issues at individual and community levels	# of performances # of people reached	Interview reports Implementation reports

STRATEGIC PHASES	ACTIVITIES	ACTIVITY OBJECTIVES	MONITORING INDICATORS	MEANS OF VERIFICATION
Impact Evaluation and Reporting Phase				
Evaluation	Organize field activity monitoring and facilitation activities	Provide guidance Identify challenges and opportunities	Quality of support Quality of report	Interviews/photos Field monitoring reports
	Monitor activities, outputs/short-term impact	Assess progress Document best practices	# of reports produced # of success stories documented	Reports/photos
	Conduct KAP studies Formative researches	Assess knowledge, attitude and practices and other gaps	Report of KAP study Formative research report	KAP studies and report

9. ADDITIONAL RESEARCH NEEDED

In order to promote effective messages and have a strong impact on behaviors and health outcomes, strengthening research activities in the area of SBCC for maternal, newborn and child health is an important objective for the health sector. It is essential to build innovative and evidence-based SBCC activities. In this regard, two additional research activities are proposed in this sub-strategy: creating in-depth, specific audience profiles; and holding focus group discussions with the audiences defined in this sub-strategy to obtain qualitative data on knowledge, attitudes, practices, and other barriers and motivators for behavior change.

Based on the results of these activities, targeted and specific messages using innovative approaches will be developed to appropriately and effectively reduce barriers and build on motivators for behavior change among individuals, families and communities. Finally, the results of formative research will inform future planning for SBCC.

10.IMPLEMENTATION PLAN AND ESTIMATE BUDGET

This sub-strategy is proposed to be implemented during the period of 2012–2015.

ACTIVITY	2012				2013				2014				2015	Response/ Institution	Budget 2012–07 (US$)
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1–3		
Reproduction of the sub-strategy document	X													MoH/partners including MCHIP	3,000
Dissemination of the sub-strategy	X													MoH/partners including MCHIP	1,500
Partnership and coordination meeting to establish roles, complementarily and accountability among partners and roadmap for joint interventions/ implementations	X													MoH/partners including MCHIP	3,000
Workshop to review existing/develop/adaptcommunication materials		X												MoH/partners including MCHIP	3,500
Production of new communication materials			X	X	X									MoH/partners including MCHIP	5,000
Advocacy meeting with religious leaders nationally and one in each focus district			X											MoH/partners including MCHIP	3,000
Partners' orientation workshops to set up multiple and sustained community engaging points in intervention zones		X	X											MoH/partners including MCHIP	500
Community-based religious sermons, meetings and follow-up home visits on key practices				X	X	X	X	X	X	X	X	X		MoH/partners including MCHIP	3,000
Development, testing and production of TOT training materials for community health workers, women leaders, religious leaders, youth leaders, men on the key health practices to promote		X	X											MoH/partners including MCHIP	30,000
Development of a training module on interpersonal communication skills for health workers		X	X											MCHIP/MoH/ MoE/BCCTWG	15,000
One TOT workshop on key practices in districts of intervention and facilitating community dialogue				X										MoH/partners including MCHIP	15,000

ACTIVITY	2012				2013				2014				2015	Response/ Institution	Budget 2012–07 (US$)
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1–3		
TOT session for community health workers, volunteers, religious, women, men and youth leaders, environmental health workers, on key health practices in district of intervention					X	X	X							MoH/partners including MCHIP	5,000
Advocacy meeting with MoE and ORINFOR to target teachers as facilitators of young adolescents in schools and "captains and coaches" around schools for RH and family planning linking with media clubs	X													MoH/partners including MCHIP	500
Development of outline on key practices for inclusion within media clubs debates		X												MoH/partners including MCHIP	1,500
TOT and training workshops on key practices targeting teachers and how to provide life skills training to children on the practices			X	X	X									MoH/partners including MCHIP	15,000
Community health workers and volunteer capacity building on communicating health messages						X	X	X	X	X	X	X		MoH/partners including MCHIP	20,000
One national-level and 5 province-level training and production workshop for radio broadcasters and editors		X												MoH/partners including MCHIP	9,000
Radio broadcasting of spots and programs			X	X	X	X	X	X	X	X	X	X		MoH/partners including MCHIP	7,500
Content production workshop for drama groups		X												MoH/partners including MCHIP	7,500
Drama groups performances			X	X	X	X	X	X	X	X	X	X		MoH/partners including MCHIP	18,000
Production and reproduction of communication materials for primary and secondary audiences and community workers, leaders and volunteers	X	X			X	X			X	X				MoH/partners including MCHIP	25,000
Monitoring of activities, outputs/short-term impact	X	X	X	X	X	X	X	X	X	X	X	X		MoH/partners including MCHIP	5,000
Evaluation: Midterm evaluation and final evaluation							X					X		MoH/partners including MCHIP	20,000
Running costs														MoH/partners including MCHIP	150,000
TOTAL US$371,500															

11. MONITORING AND EVALUATION

Knowing the impact of a communication strategy, especially on specific health objectives, is crucial. Program planners may assume that improving knowledge will lead to changes in attitudes and behavior; however, proving that a specific intervention caused a behavioral outcome is extremely difficult. The contributing roles of the diverse and complex factors that affect human choices are difficult to measure. Quantitative research can help measure individual and societal changes, and qualitative research can help identify, explain and assess the factors that caused or inhibited those changes.

Evaluation of SBCC involves measuring indicators at various stages. Formative evaluation includes research at the beginning of an intervention; monitoring assesses the reach and effectiveness of an intervention while it is occurring; and summative evaluation assesses changes in knowledge, attitudes, beliefs, self-efficacy and perceived risk following a midterm or long-term intervention. Surveys, randomized trials or epidemiological data can be used to measure the effectiveness of an SBCC, but this requires significant time and resources. Consequently, many SBCC evaluations use quasi-experimental or post-test designs to demonstrate the influence of a given intervention in producing desired changes.

Measuring behavior change is difficult. It is easier to evaluate an intervention that is based on a well-planned strategy, has clear goals and objectives, and is grounded in a theoretical model from the outset. Initial project plans or SBCC strategies should include a plan for monitoring and evaluation that includes clear outcome indicators to determine if the interventions were effective.

To the extent possible, monitoring and evaluation should be designed as participatory processes that involve stakeholders to assess and solve problems and refine programs. Participatory monitoring relies not on outside experts to determine successes, but asks people involved in a program to determine the criteria for assessing its strengths and weaknesses. This approach promotes dialogue and builds skills and capacity of local organizations, local leadership and community members.

This SBCC Sub-Strategy for MNCH and M&E Plan provide the basis for quality reporting. In order to measure progress toward achieving the SBCC Sub-Strategy for MNCH communications objectives, key indicators have been defined in the communication objectives as well as in the strategic planning. This part will define how the monitoring and evaluation will be done and at what frequencies data will be collected. It also reviews the relevant indicators and measures of impact, outcomes and program performance that will be used for both monitoring and evaluating various elements of the SBCC Sub-Strategy implementation plan.

11.1 SBCC SUB-STRATEGY FOR MNCH MONITORING AND EVALUATION PLAN

11.1.1 Goal and Objectives

The goal of an M&E plan of this SBCC Sub-Strategy is to provide a framework for obtaining reliable information to determine progress in the implementation of designed social and behavior communication interventions, and inform decisions for health program management and improvement.

The objectives of the M&E plan are:

- To set the framework for development of Standard Operating Procedures for the collection, processing, analysis and use of social and behavior change communication data on MNCH in Rwanda
- To outline key actions for implementing social and behavior change communication monitoring and evaluation in Rwanda
- To guide the monitoring of planned communication activities, measure expected outcomes and impact

11.1.2 Monitoring and Evaluation Plan

Key indicators have been defined to be tracked all along the implementation of this SBCC Sub-Strategy depending on the indicator level, timeframe of the implementation and what is being measured:

- Input indicators will be measured continuously as interventions are implemented.
- Process indicators will be measured quarterly, semi-annually or annually.
- Output indicators will be measured quarterly, semi-annually or annually.
- Outcomewill be measured at midterm implementation or after two years of implementation.
- Impact indicators will be measured during the third year of the sub-strategy implementation.

Monitoring the communication interventions or routine tracking of the key elements of program performance is done through record keeping, regular reporting, surveillance systems and periodic surveys such as health facility observation and client surveys. In this sub-strategy more specifically, monitoring will involve generating data during field visits or from reports on communication input (human resources, financing, supplies), process (procurements and training) and output(demand of services or quality of service delivered) indictors over a planned time. It will assess the extent to which the implementation of planned activities is consistent with the communication plan designed and determine which areas require more focus and at which level (national or district) to improve performance.

Baseline assessment and evaluation or periodic situation analysis or assessment aim at evaluating change resulting from a health program. It attempts to link a particular health outcome or impact directly to communication interventions after a period of time, and investigate and determine the value or worth of the communication strategy, highlighting its cost efficiency or gaps, using appropriate techniques including social research methods. In this SBCC for MNCH, baseline surveys are proposed to gain more insight on the key audience targeted in most of the behaviors to promote. There is a need to know why they behave as they do and focus on communicating with them. Periodic assessments and formative researches are proposed to guide this three-year period sub-strategy implementation. Result reports of the assessments will be regularly produced and shared to inform key planning decisions.

12. CONCLUSION

Due to the increasing importance of integrating social and behavior change communication into health planning, programming and implementation, it has become critical to have a document guiding this area of activity for the health sector.

Thus, this *Social and Behavior Change Communication Sub-Strategy for Maternal Newborn and Child Health* and the *National Behavior Change Communication Policy for the Health Sector* will contribute to the efforts of the Ministry of Health and the Government of Rwanda to implement the Economic Development and Poverty Reduction Strategy targeting both the MDG health indicators and the Vision 2020 objectives to improve the health of every Rwandan citizen. Both the policy and the sub-strategy are based on the following:

- Empowering people with the necessary skills and information for them to make informed health choices
- Systematic, participatory planning in collaboration with stakeholders to develop, implement and monitor evidence-based BCC interventions
- Encouraging the use of different strategic interventions (such as social and community mobilization, behavior change communication, advocacy), combined with a range of channels and tools to enhance health promotion activities among different key audiences
- Coordinating, information sharing and building partnerships among different stakeholders to increase the impact of social and behavior change communication interventions

Social and behavior change communication strategies and interventions are not a stand-alone process. They are an integral part of the overall Health Sector Strategy, and it is well-proven that in order to maximize their impact, coordination and mutual support among the different programs to be implemented by the health sector is vital.

Social and behavior change communication strategies follow and support the major objectives of the Ministry of Health, especially the decentralization of health services and community participation, from the planning to the evaluation stage, as well as local capacity building.

APPENDIX 1.BEHAVIORAL ANALYSIS FOR SIX PRIORITY MNCH THEMES

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
1. FAMILY PLANNING, REPRODUCTIVE HEALTH, AND CERVICAL CANCER						
Overall Objective - Family Planning/Reproductive Health: Increased utilization of FP services from 45% in 2010 to 71% by 2015						
Pregnancy among adolescent girls	Unprotected sex and limited knowledge on how pregnancy occurs	Adolescent girls delay first sexual encounter Sexually active adolescents practice safe sex (i.e., correct and consistent condom use, and secondary virginity)	**Primary Audience:** ▪ Girls 10–14 ▪ Girls 15–19 ▪ Girls 20–24	Interpersonal communication	Face-to-face communication Group counseling	Key info on reproductive health, sexuality and prevention of unwanted pregnancies Importance of consistent safer sex including condom use Life skills
			Secondary Audience: ▪ Parents ▪ Teachers ▪ Sexual partners of the primary audience ▪ Boys 10–14 ▪ Boys 15–19 ▪ Boys 20–24	Social mobilization Community mobilization	Mass media Community and group events	Key info on reproductive health and sexuality Importance of youth friendly RH services and VCT
			Tertiary Audience: ▪ Religious leaders ▪ CSO	Advocacy	Advocacy events	Importance of sex education and family/partners dialogue

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Frequent unplanned, untimed and unspaced pregnancies of women	Belief that large family size gives social status Unilateral decision on childbearing by men Limited use of FP methods Limited knowledge on impact of pregnancies on women's health Desire for children of a particular sex; boys are more important than girls Men are not supportive to FP Rumors on FP	Women and their partners/husbands plan pregnancies by delaying, spacing and limiting births	**Primary Audience:** ▪ Women 19–24 ▪ Women 25–49	Interpersonal communication	Face-to-face Group counseling Peer education Home visits	Key info on FP Benefits of planned, timed and spaced pregnancies on health and household wealth
			Secondary Audience: ▪ Partners/husbands ▪ CHWs ▪ Media	Community mobilization Mass media Capacity development	Radio talk shows Church events Community level meetings Group associations Folk media including interactive popular theatre and group discussions Training, role modelradio serial dramatestimonies	Importance of birth planning on mothers' health Support girls and women to plan, time and space pregnancies (material, moral) Importance of male involvement
			Tertiary Audience: ▪ Government authorities ▪ Opinion leader ▪ Religious leaders ▪ Community leaders	Advocacy	Advocacy meetings Radio talk shows Sermons Conferences	Advocate for provision of appropriate service personnel and infrastructure Communicate the benefits of family planning as appropriate

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Overall Objective – Cervical Cancer: Increase complete HPV vaccination to 100% for all 12–15 girls and screening for cervical cancer for women aged 30–35						
Some girls aged 12–15 go for HPV immunization	Parents discourage their girls aged 12–15 for HPV immunization due to: Rumors around HPV vaccine Poor communication by community outreach teams	Young girls 12–15 are fully immunized against HPV	**Primary Audience:** ▪ Girls in and out of school aged 12–15 ▪ Parents ▪ Caregivers	Mass media Interpersonal communication	Radio serial drama Dialogue within families Peer education by CHWs	Key information on cervical cancer Benefits of HPV vaccine
			Secondary Audience: ▪ Parents, teachers, household members	Social mobilization Community mobilization	Community outreach Edutainment Community dialogue	Importance of HPV for girls Motivating girls to go for HPV immunization
			Tertiary Audience: ▪ CHWs, FBOs and CBOs, CSOs ▪ Youth structures ▪ Local authorities	Advocacy	Advocacy campaign Media (radio) Sensitization meetings	Importance of a supportive environment; policies; quality services and products; address social barriers; initiate public discussion; allocate resources for HPV immunization
Women of reproductive age do not screen for cervical cancer	Lack of knowledge of cervical cancer Limited knowledge about screening Poor communication by community outreach teams Lack of awareness on the cervical cancer Limited knowledge about screening	HIV-positive women aged 30–45 years and HIV-negative women aged from 35–45[15] years go for cervical cancer screening	**Primary Audience:** ▪ Women of reproductive age	Mass media IPC	Radio talk shows Radio serial drama Group event	Key information on cervical cancer Benefits of screening Importance of the screening
			Primary Audience (2): ▪ HIV-positivewomen enrolled in PMTCT		Face-to-face with CHW Face-to-face with counselors	
			Secondary Audience: ▪ Husbands/partners ▪ Women in associations	Social mobilization	Community outreach mobilization activities Radio talk shows	Key information on cervical cancer: What? causes, signs and how to prevent it what we want people to do Importance of screening Importance of peer/man support
			Tertiary Audience: ▪ FBOs, CSOs ▪ Media development partners ▪ Women in associations	Advocacy Sensitization	Talk shows, person to person Breakfast meeting Conference	Promote screening; create supportive environment; advocate for policies; policies, services and products

[15]MoH strategic plan for cervical cancer.

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
2. MATERNAL AND NEWBORN HEALTH						
Overall Objective - Maternal Health: Reduce maternal mortality from 383 to 300 per 100,000 live births by 2015 **Overall Objective - Newborn Health: Reduce neonatal mortality from 27% to 10% by 2015 (the goal was 15% by 2012—EDPRS)**						
Unsafe abortion by pregnant adolescents girls and women	Insufficient knowledge on the dangers of unsafe abortion Unwanted and unplanned pregnancies Failure to seek medical care after unsafe abortion	Adolescent girls and women who have abortion seek medical care afterwards (PAC –postabortion care services)	**Primary Audience:** ▪ Adolescent girls ▪ Women of reproductive age	Interpersonal communication Mass communication	Face-to-face Peer education Radio drama Radio talk shows and discussions	Key info on sexual and reproductive health, including family planning Dangers of induced abortion and importance of postabortion care) Information on PAC services
			Primary Audience: ▪ PAC service providers	Capacity building	Training mentorship	Counseling kits, job aids
			Secondary Audience: ▪ Partners of adolescent girls and women of reproductive age ▪ Parents	Social mobilization	Mass media Social/community events using drama and songs	Key facts to promote family planning , safe sex; safe practices including quality care and PAC
			Tertiary Audience: ▪ Local leaders	Advocacy	Meetings/conferences	Advocate for availability of PAC and qualified health providers Available contraceptives and other products
Pregnant women do not go for early ANC and HIV testing	Cultural belief of not disclosing pregnancy at its early stage Limited knowledge of benefit of ANC and adherence to PMTCT programs	Every woman starts ANC as soon as pregnant and test for HIV Every pregnant woman attends all four recommended ANC visits before delivery	**Primary Audience:** ▪ Pregnant women	Interpersonal communication	Face-to-face counseling by CHW or health care providers Peer education	Benefits of early ANC and PMTCT for both mother and child Address misconceptions around early disclosure of the pregnancy
			Secondary Audience: ▪ Husbands/partners ▪ Immediate family members ▪ Health care providers ▪ CHWs	Community mobilization and participation	Group counseling; mass media; community events using drama, songs, poems	Facts and benefits of both partners attending early ANC and PMTCT; quality care; importance of support to pregnant women to seek early ANC services
			Tertiary Audience: ▪ Religious leaders, CSOs, women's groups, local authorities	Advocacy	Meetings and conferences	Advocate for social change addressing misconceptions around pregnancies

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Pregnant women not making the four ANC (only 35 % do)	Limited knowledge on the importance of early ANC Healthy pregnant women perceive ANC as waste of time Some pregnant women not satisfied with ANC services do not go for the subsequent visit	Every pregnant woman attends all four recommended ANC visits before delivery	**Primary Audience:** ▪ Pregnant women	Interpersonal communication	Face-to-face and group counseling by CHW Peer education	Benefits of the four minimum visits: ▪ Confirm or rule out the pregnancy ▪ Avoidance of risks linked to unmonitored pregnancy
			Secondary Audience: ▪ Spouse, family, CHWs, health care providers	Community mobilization and participation	Group counseling Community events using drama, songs and poems; mass media; phone calls/SMS	Encourage pregnant women to attend all the four recommended minimum visits
			Tertiary Audience: ▪ Women's groups/CSOs, local authorities	Advocacy	Meetings/conferences	Advocate for enough skilled health providers
Pregnant women do not recognize danger signs, deliver at home and do not report to the health facility for both herself and the newborn postnatal care	Ignorance of danger signs There is no one to accompany the mother to the health facility Financial constraints to meet the costs especially without mutuelle Delayed birth preparedness and decision-making Limited knowledge on need of postpartum care	Every pregnant woman should recognize dangers signs of pregnancy and seeks care immediately at a health facility	**Primary Audience:** ▪ Pregnant women	Interpersonal communication Mass communication	Face-to-face and group counseling by CHW Peer education	Danger signs of pregnancy Risks linked to home delivery; importance of immediate postnatal care for both the mother and the newborn Importance of adhering to health scheme Birth and emergency preparedness kit including financial Importance of receiving quality care from a skilled birth attendant
			Secondary Audience: ▪ Husbands/partners ▪ CHWs ▪ Health care providers ▪ Women's groups	Community mobilization and participation	Community outreach edutainment Radio talk shows and serial drama Mass media	Danger signs during pregnancy and benefit of assisted delivery Address the social norms barriers
			Tertiary Audience: Local authorities, CSOs Development partner	Advocacy	Advocacy meetings	Advocate for adequate maternity wards and waiting rooms

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Health care providers do not provide quality antenatal, delivery and postnatal care services to all pregnant women	Limited capacity to provide quality care Limited knowledge on the quality care package for mother and newborn including KMC methods and its benefits	Every health care provider provides quality antenatal, delivery and postnatal care services to all pregnant women and their newborns including special care of the low birth weight infants	**Primary Audience:** Health care providers at ANC	Capacity development	IPC and counseling Training sessions	Info on risks linked to postnatal period if not properly managed; postpartum package and counseling including FP, postnatal visit, maternal nutrition, IYC nutrition Key info on the benefits of practicing the KMC for premature and low birth weight
			Secondary Audience: ▪ Health administrators and local leaders in-charge ▪ Birth attendants, CHWs	Social mobilization on KMC practice and care of newborn	Meeting and conferences	Promote postnatal care Promote KMC: ▪ Process and practice; ▪ Encourage adoption of practice
			Tertiary Audience: ▪ Maternal and child health policymakers ▪ Health care providers ▪ Women's groups, CSOs ▪ Local authorities	Advocacy	Advocacy meetings Capacity building forums	Advocate for the promotion of a comprehensive postnatal package Share experience/stories from other countries on KMC's added value

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
3. MATERNAL, INFANT AND YOUNG CHILD NUTRITION; ENVIRONMENTAL HEALTH, HYGIENE AND SANITATION						
Overall Objective - Maternal Nutrition: Increase intake of nutrient-rich foods by pregnant and lactating women						
Pregnant and lactating women do not eat nutritious food in the right quantity	Lack of awareness on lactating and pregnant women's appropriate nutritional needs Lack of information on what to eat Families sell most nutritious food items, leaving not enough quantity for family consumption Limited involvement of men in issues that concern their women's nutrition Taboos around food due to personal and religious beliefs Large family size impacts how much each gets to eat, so mothers sacrifice themselves for children	Pregnant women eat daily an extra meal or a snack that contains food rich in energy, vitamin A or iron Lactating mothers eat daily two extra meals or snacks that contain foods rich in energy, vitamin A or iron Pregnant women receive and take at least 90 iron-folic acid supplements	**Primary Audience**: ▪ Pregnant women ▪ Lactating women	Interpersonal communication	Face-to-face Home visits Counseling by CHWs Talks at ANC	Benefits of appropriate nutrition for pregnant and lactating women on the health of the mother and the newborn Address misconceptions—lack of breast milk production, foods—which hinder social harmony (additional research needed) Benefit of family planning on nutritional status of the pregnant woman
			Secondary Audience: ▪ Husbands/male partners ▪ Family members ▪ CHWs, peers, CBOs, FBOs	Community mobilization and participation	Radio talk show, talks and discussions at Umuganda, church and mosque events Drama for community outreach Mobile cinema	To support appropriate pregnant women nutrition Experience, role models, stories, testimonies and cases Promotion of family planning
			Tertiary Audience: ▪ FBOs, CHWs ▪ Health providers ▪ Local leaders	Advocacy	Nutrition advocacy meetings/campaigns	Importance of appropriate nutrition for pregnant and lactating women Support household in resources management Gender in decision-making and power relations

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Overall Objective - IYCN: Reduce the proportion of children 0–23 months who are stunted						
Mothers do not practice exclusive breastfeeding for the first 6 months	Give hot water at the first hour after birth to clean the stomach of the baby – insufficient knowledge about the nutrients in the colostrum Working lactating mothers interrupt exclusive breastfeeding after 1 month to go back to work Lack of supportive mechanisms to promote exclusive breastfeeding at work place	Mothers should exclusively breastfeed for the first 6 months of life, give nothing to the baby but breast milk – no food or other liquids, not even water	**Primary Audience:** ▪ Pregnant and lactating women	Interpersonal communication	Peer education and counseling by CHWs and health workers at ANC visits and Child Growth Monitoring and Promotion (GMP)	Importance of breast milk for the child's growth (contains all nutrients and enough water for the young child) Benefits of early and exclusive breastfeeding
			Secondary Audience: ▪ Husbands/male partners ▪ Birth attendants, nurses ▪ Health providers/ ▪ Midwives, CHWs or maternal community health workers	Community mobilization and participation	Radio talk shows; group counseling in association, church and mosque Radio serial drama, radio spots	Comprehensive facts on colostrum and how it contribute to the child immunity system Promote early initiation Importance of supporting the lactating women for exclusive breastfeeding
			Tertiary Audience: ▪ FBOs, CHWs; CSOs ▪ Members of Parliaments; National Women's Council; MIGEPROF	Advocacy	Advocacy and orientation meetings Radio talk shows	Advocate for policies and structures to support early initiation of breastfeeding Promote exclusive breastfeeding practice
Mothers and caregivers do not practice appropriate complementary feeding	Lack of information and/or resources for appropriate complementary feeding	Mothers practice age-appropriate complementary feeding starting at 6 months until 23 months while continuing to breastfeed	**Primary Audience:** ▪ Lactating mothers ▪ Caregivers	Interpersonal communication	Face-to-face and group counseling by CHWs and health workers during postnatal care visits and Child Growth Monitoring and Promotion (GMP)	Facts on appropriate complementary feeding between 6–4 months (6–9; 9–12; 12–24)
			Secondary Audience: ▪ Husbands and male partners; family members, peers	Community mobilization and participation	Radio, talks and discussions at community CBN food demonstrations	Support mothers/empower mother in appropriate infant feeding: what and how? (community-based nutrition)
			Tertiary Audience: ▪ CHWs, FBOs, women's associations, CSOs; Parliamentary Caucus on Social Welfare	Advocacy	Orientation meetings Radio talk shows	Mechanisms that promote and support appropriate complementary feeding

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Overall Objective - Personal Hygiene: Improve personal hygiene habits including those habits that affect disease transmission in children						
Poor personal hygiene of mothers, caregivers of children and children under 5	Ignorance on the importance and benefits of personal hygiene No accessibility to clean water	Mothers and caregivers bathe at least once a day, put on washed clothes including underwear every day and clean their teeth twice a day Mothers and caregivers bathe children under 5 at least once a day, put washed clothes on them at least once a day and every time needed, and clean their teeth twice a day	**Primary Audience:** ▪ Mothers of children under 5 ▪ Caregivers of children under 5	Interpersonal communication	Face-to-face Group counseling by CHWs and environmental health officers	Benefits of good body hygiene on child and maternal health
			Secondary Audience: ▪ Husbands/fathers, mothers-in-law/grandmothers ▪ Children in school ▪ PHAST Committees	Community mobilization and participation	Radio a talk shows Discussions at Umuganda, sensitization on personal hygiene during church and mosque events	Provide support and quality service to promote and sustain good hygiene practices
			Tertiary Audience: ▪ CHWs, FBOs, women's associations, CBOs ▪ Local leaders	Advocacy	Orientation meetings Radio talk shows on personal hygiene	Importance of providing key hygienic products (water, soap, latrines) – accessible; and promote body hygiene practices
Handwashing with soap not practiced by mothers and caregivers of children under 5	Handwashing with soap is not a habit No accessibility to clean water	All mothers/caregivers wash their hands with soap or ashes after contact with excreta (including after cleaning up after babies) and before preparing food All mothers/caregivers wash their hands and children's hands with soap or ashes before feeding the child	**Primary Audience:** ▪ Mothers of children under 5 ▪ Caregivers of children under 5	Interpersonal communication	Face-to-face Demonstration of handwashing with soap and personal hygiene by PHAST committees	Benefits of handwashing with clean water and soap The four critical times for handwashing
			Secondary Audience: ▪ Husbands/fathers ▪ Family members ▪ Children in schools	Community mobilization and participation	Radio serial drama Community meetings Umuganda event Community outreach edutainment event	Promote handwashing with soap practice Diseases that could be avoided through observing clean hands
			Tertiary Audience: ▪ PHAST Committees,CHWs,FBOs, CBOs, women's associations ▪ Local leaders	Advocacy	Meetings/campaigns using job aids with steps on handwashing with soap after four critical times	Need to available products and tools such as dish drier table, (Kandagiraukarabe-Kanakara)

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Poor excreta disposal practices in the homes and in schools	Homes lack hygienic latrines Improper use of latrines: dirty, poor disposal of anal cleaning materials No covering the hole Improper disposal of children feces (belief that children's feces are not harmful)	Each family member disposes all feces included children's in a safe, hygienic latrine	**Primary Audience:** ▪ Mothers/caregivers	Interpersonal communication	Face-to-face Peer education	Benefits of proper excreta disposal and proper use of toilet
			Secondary Audience: ▪ Fathers/husbands, ▪ CHWs, health providers, Teachers; PHAST Committees/Community Hygiene Committees	Community mobilization and participation	Talks and discussions at Umuganda, church and mosque events Orientation meetings Radio discussions/talk shows	Importance of a hygienic latrine Importance of proper disposal of children's feces
			Tertiary Audience: ▪ Community leaders ▪ Administrative authority, FBOs, CBOs	Advocacy	Hygiene campaigns Live radio/TV talk shows with calls in	Introduce adequate infrastructures (latrines and water) and hygienic products– soap, Kanakrato, clean hands after the four critical times
Poor ventilation and lighting of homes leading to ARIs (acute respiratory infections) and poor eyesight	Lack of awareness on the importance of ventilation House windows are not of appropriate size Families use open wood fires to cook in their rooms	Families ventilate their homes	**Primary Audience:** ▪ Fathers/mothers	Interpersonal communication	Face-to-face Group Counseling by CHWs and radio drama, radio spots; talks and discussions at Umuganda	Importance of building wood saving stoves on family health Importance of ventilation on the health of family members
			Secondary Audience: ▪ Family members ▪ Community leaders, FBOs,builders of homes	Community mobilization and participation	Radio Talks and address at Umuganda, church and mosque events	Support, promote the use of wood saving stoves
			Tertiary Audience: ▪ District environmental health officer, technology innovators	Advocacy	Radio discussions/talk shows Demonstration of model home ventilation type	Advocate for innovations in sanitation and environmental hygiene

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Community members do not clear mosquito and other insects breeding sites around homes	Lack of awareness on importance of clean compound on health Limited knowledge on conducive environment for mosquito growth	Families regularly clear mosquito-breeding sites around houses	**Primary Audience:** ▪ Husbands ▪ Wives	Interpersonal communication	Face-to-face Home visits	Benefits of a clean house and compound in eradicating malaria and other diseases Key info on hygienic practices (environment care, remove stagnant water, pot holes, grass, bushes, broken pots, domestic animal waste)
			Secondary Audience: ▪ Family members ▪ CHWs	Community mobilization and participation	Radio spots Talks and addresses at Umuganda, church and mosque events	Key information on conducive environment for mosquito growth Role modeling
			Tertiary Audience: ▪ Community leaders ▪ District environmental health officer	Advocacy	Advocacy meetings Radio discussions/talk shows	Advocate for appropriate affordable tools for environment cleaning Model the right behavior, engage the community (performance contract–imihigo + rewards)
People keep animals in their rooms or under beds	Lack of awareness on importance of clean compound on maternal and child health	Families keep domestic animals in a pen or poultry away from living and cooking spaces	**Primary Audience:** ▪ Husbands ▪ Wives	Interpersonal communication	Face-to-face Home visits	Benefit of keeping domestic animals away from people's place
			Secondary Audience: ▪ Members of the family ▪ CHWs	Community mobilization and participation	Radio spots Talks and address at Umuganda, church and mosque events	Promote benefits of keeping domestic animals in stables and poultry (healthy lives)
			Tertiary Audience: ▪ Community leaders ▪ Environmental health officers ▪ Opinion leaders ▪ Women's and youth structures	Advocacy	Advocacy meetings Radio discussions/talk shows	Provide guidelines on appropriate domestic animals stable Sensitize each household to build a stable

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
4. COMMUNITY AND FACILITY IMCI, EPI (INCLUDING VITAMIN A AND DE-WORMING), MALARIA, ARIs, DIARRHEA						
Overall Objective - EPI: to contribute to the improved well-being of the Rwandan people through reduction of child morbidity and mortality due to vaccine preventable diseases (Source: EPI Strategic Plan)						
Mothers and caregivers of children under 5 are not taking children to health facilities for immunization	Population movements limited communication to reach out to some mothers/caregivers of children under 5	Mothers and caregivers of children under 5 take all eligible children for all scheduled immunization including vitamin A and de-worming	**Primary Audience:** ▪ Parents ▪ Caregivers of children under 5	Interpersonal communication	Group counseling Mass media	Benefits of immunization Immunization calendar Addressing misconceptions around immunization
			Secondary Audience: ▪ CHWs, relatives (grandmothers, mothers-in-law)	Social mobilization Peer education	Community outreach edutainment Mass media Mobilization campaign Trainings and meetings	Support mothers and care givers of children under 5 Provide quality services
			Tertiary Audience: ▪ CSOs, FBOs ▪ Community leaders	Advocacy	Advocacy campaign Social events Traditional communication channels	Advocate for advanced strategies to reach out all mother including marginalized and hard to reach Available resources and products at reach
Overall Object - Malaria: Universal ownership and use of long-lasting insecticide-treated nets (LLINS) for malaria prevention (Source:HSSP II 2009-2012)						
Some children under 5 and pregnant women do not sleep under LLINs	Poor understanding of the benefits of sleeping under LLINs Wrong perception on LLINs (hot, not efficient, problems hanging) Parents misuse LLINs supplied to them (fishing, henhouse, etc.)	Every child under 5 and all pregnant women sleep under LLINs every night	**Primary Audience:** ▪ Parents of children under 5	Interpersonal communication	Face-to-face Group counseling Peer education	Key facts on benefits of using LLINs Key info on the management of the LLINs (washing, proper hanging)
			Secondary Audience: ▪ CHWs ▪ CSOs	Social mobilization Social marketing	Mass media Community outreach through edutainment Trainings	Support mothers of children under 5 and pregnant mothers on how to use LLINs
			Tertiary Audience: ▪ Community leaders ▪ Health providers	Advocacy	Mass media Meetings/conferences	Advocate for quality service and availability of products Set up LLINs distribution and use monitoring mechanisms
			Primary Audience: ▪ Parents of children under 5 ▪ Caregivers of children under 5	Interpersonal communication Edutainment Social mobilization	Face-to-face Group counseling Peer education	Key information on fever, malaria symptoms; harmful practices and consequences; preventive measures; case management

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Children under 5 who have fever are not taken to health providers within 24 hours for appropriate treatment	Lack of awareness of danger of fever on child health Financial constraints Non-enrollment in community health insurance scheme Wrong beliefs (curse)	Mothers/caregivers of children under 5 seek appropriate care and treatment for a child with fever within 24 hours	**Secondary Audience:** ▪ Family members (grandmothers, mothers-in-law) ▪ CHWs ▪ Leaders of FBO	Social mobilization	Mass media Community outreach through edutainment	Key info on fever, malaria symptoms; harmful practices and consequences, preventive measures; support case management Importance of enrolment in mutuelle
			Tertiary Audience: ▪ CSO ▪ Community and opinion leaders ▪ Traditional healers ▪ Health providers ▪ Local authorities	Advocacy	Mass media Meetings	Need to avail support systems, product and quality services at community level (CHW, mutuelles, POSACOM)
Overall Objective - ARIs: Reduce morbidity and mortality of children under 5 from acute respiratory infections (ARIs) (Source: IMCI Strategic Plan)						
Mothers/caregivers do not recognize signs of ARIs among children under 5 nor seek appropriate care	Insufficient knowledge of danger signs of ARIs in children under 5 and under 2 months Children: ▪ Limited knowledge on prevention of ARIs including immunizationhy giene and home ventilation ▪ Geographical inaccessibility	Mothers/caregivers recognize signs of ARIs and seek appropriate care for children under 5 with ARIs	**Primary Audience:** ▪ Mothers of children under 5 ▪ Caregivers of children under 5	Interpersonal communication	Face-to-face Peer education	Key info on pneumonia, danger signs and harmful practices; consequence and preventive measures
			Secondary Audience: ▪ Fathers ▪ Grandmothers ▪ CHWs	Social mobilization	Group counseling Mass media Community outreach through edutainment	Key info on danger signs and harmful practices; consequence and preventive measures Provide quality service
			Tertiary Audience: ▪ FBOs ▪ Community leaders ▪ Traditional healers	Advocacy	Social events Meetings/conferences	Sensitize for adherence to health systems at community level (CHW, mutuelles, POSACOM)

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Mothers/caregivers do not complete prescribed treatment when their child under 5 falls sick	Non enrollment in community health insurance scheme Ignorance of effect of discontinuing prescribed treatment dose	Mothers/caregivers of children under 5 complete prescribed treatment for all illnesses	**Primary Audience:** ▪ Mothers/caregivers of children under 5	Interpersonal communication	Face-to-face Group counseling Peer education	Key info on childhood illnesses and management Benefits of adhering to mutuelles
			Secondary Audience: ▪ Fathers, family members ▪ CHWs	Social mobilization	Group counseling Mass media	Provide support to mothers of infants and children under 5 in management of childhood illnesses
			Tertiary Audience: ▪ FBOs, Community leaders ▪ Media journalists	Advocacy	Mass media Advocacy events	Advocate for accessibility of health services and availability of products Advocate for improved referral capacity for the CHWs
Overall Objective – Diarrhea: To reduce morbidity and mortality in under-5 children due to diarrheal diseases (Source: IMCI Strategic Plan)						
Mothers/caregivers do not recognize danger signs of diarrhea in infants and children under 5 and do not give them ORS and other recommended fluids and treatment	Insufficient knowledge of danger signs of diarrhea for infants and children under 5 Limited knowledge of benefits of ORS Limited capacity to prepare ORS at home	Mothers/caregivers recognize danger signs of diarrhea in infants and children under 5 and manage it as recommended with ORS and fluids and other treatment	**Primary Audience:** ▪ Mothers/caregivers of children under 5	Interpersonal communication	Face-to-face Peer education	Facts on dangers signs of diarrhea Storage and preparation of food for a child suffering from diarrhea Preparation of ORS
			Secondary Audience: ▪ Fathers, family members; CHWs	Social mobilization	Group counseling Mass media Community outreach through edutainment	Key steps in diarrhea management Hygiene practices to prevent diarrhea
			Tertiary Audience: ▪ CSOs, FBOs, CBOs ▪ Community leaders ▪ Local authorities	Advocacy	Mass media Social/community dialogue	Advocate for accessible infrastructure Available water purification products at affordable cost
Mothers/caregivers do not seek/delay seeking appropriate treatment or referral from CHWs or health providers for their children under 5 suffering from diarrhea	Insufficient knowledge of danger signs of diarrhea for children under 5 Influence of traditional healers Non enrollment in Mutuelle Inaccessibility Lack of trust CHWs'	Mothers/caregivers of children under 5 suffering from diarrhea seek appropriate care from health providers without delay	**Primary Audience:** ▪ Mothers, caregivers of children under 5	Interpersonal communication	Face-to-face Group counseling Peer education	Key info on danger signs of diarrhea; prevention measures; management of diarrhea case at household level
			Secondary Audience: ▪ Fathers, family members ▪ CHWs ▪ Health providers	Social mobilization	Training Community outreach through edutainment	Key facts on diarrhea, sensitize mothers to seek appropriate care without delay at health facility
			Tertiary Audience: ▪ Community leaders	Advocacy	Mass media Meetings	Advocate for accessibility of services and products

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
	capacity		▪ Policymakers		Advocacy events	
Mothers/caregivers of children under 5 with diarrhea stop some foods including breastfeeding	Limited knowledge on the importance of continued feeding and breastfeeding while suffering or recovering from diarrhea Misconceptions	Mothers/caregivers continue appropriate feeding including breastfeeding for children suffering or recovering from diarrhea or other illness	**Primary Audience:** ▪ Mothers/caregivers of children under 5	Interpersonal communication	Face-to-face Peer education	Key info on diarrhea IYCF while managing diarrhea
			Secondary Audience: ▪ Fathers, grandmothers, mothers- and fathers-in-law CHWs, traditional healers	Social mobilization	Group counseling Mass media Community outreach through edutainment	Key instructions on management of diarrhea: ▪ Increase fluids, foods ▪ Keep breastfeeding (including exclusive breastfeeding for less than 6 months)
			Tertiary Audience: ▪ CSOs ▪ Community leaders	Advocacy	Group counseling Mass media Community meetings	Advocate for availability of product and water infrastructure near homes
Overall Objective - Community and Facility IMCI: To increase demand for health services and improve on health care quality services						
Mothers/caregivers of children under 5 practice auto medication	Ignorance of overdose or traditional medication danger Perceived distance and poor service at health facility Fathers not concerned by the child's health care	Mothers/caregivers of children under 5 seek treatment at health facility Health providers receive mothers and caregivers of sick children warmly and treat them with respect and care	**Primary Audience:** ▪ Mother and caregivers of children under 5 ▪ Health providers	Interpersonal communication	Face-to-face Peer education	Info on benefits of accessing/providing quality health care at health facilities
			Secondary Audience: ▪ Fathers, family members, CHWs; traditional healers	Social mobilization	Group counseling Mass media	Provide support to mothers/caregivers
			Tertiary Audience: ▪ CSOs, FBOs, CBOs ▪ Community leaders ▪ Opinion leaders	Advocacy	Mass media Social events Community meetings	Advocate for quality services and appropriate infrastructures and health facilities at community reach

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
5. HIV/AIDS, OTHER STIs AND TUBERCULOSIS (TB)						
Unsafe sexual practices and relationship (network) by sexually active men, women and adolescents between 15–49 year age	Limited accurate information on HIV infection and STIs Abuse of alcohol and drugs Trust Lack of power to negotiate safe sex (especially women)	Men, women and adolescent between 15–49 age have safe sex Practice safer sex, i.e., consistent condom use or stick to their partners for married couples or those in stable relationship	**Primary Audience:** ▪ Adolescents ▪ Married couples ▪ Sexual partners	Interpersonal communication	Face-to-face Peer counseling Group counseling Door-to-door	Benefits of safe sex, faithfulness Facts on HIV and STIs; life skills Address myths and misconceptions on condom use
			Secondary Audience: ▪ Parents, relatives, peers, CHWs, CBOs	Community mobilization Social marketing	Community/social events Edutainment community dialogue Mass media	Benefits of safe sex Facts on HIV and STIs Address myths and misconceptions on condom use Communication skills
			Tertiary Audience: ▪ Health service providers ▪ CSOs ▪ Leaders at all levels ▪ Opinion leaders	Advocacy	Mass media Social/community events Conferences, meetings	Advocate for condoms accessibility, role modeling; engage dialogue on social norms to remove resistance, establish supportive environment
Inconsistent use condom by HIV discordant couples and sexually active partners	Perceptions that condoms are not necessary in stable relations Rumors around condom use Low personal risk perception of HIV and STIs by adolescents HIV discordant couple in PMTCT want to have a child	HIV discordant couples use condom for every sexual contact (2.2% of heterosexualcouples are HIV sero-discordant–around 60,000couples)	**Primary Audience:** ▪ Sexually active partners, ▪ HIV discordant couples	Interpersonal communication	Face-to-face Mass media Door-to-door edutainment	Benefits of consistent condom use in prevention of HIV and STIs Negotiation skills Benefits of VCT, enrolling to PMTCT, adherence to ARVs
			Secondary Audience: ▪ Parents, peers, CHWs	Community mobilization Social marketing	Group counseling Community outreach through edutainment	Communication skills Support adherence to consistent condom use Quality services
			Tertiary Audience: ▪ FBO, leaders/ authorities at respective levels, CHWs	Advocacy	Mass media, social and community events. Conferences Meetings, community dialogue	Make condom accessible Engage community dialogue

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
Poor use of VCT services for HIV and STIs by adolescents, youth and couples with no adherence to treatment	Limited knowledge of the benefits of testing and knowing one's status Fear of knowing the status Weakness in counseling services	Sexually active couples with symptoms of STIs seek screening/medical care together and adhere to regimen	**Primary Audience (1):** ▪ Adolescents 12–18 ▪ Young people 19–30	IPC	Face-to-face Peer education Group counseling	Importance and benefit of knowing one's HIV status Information on STI and symptoms Danger of interrupting treatment Info on available services
			Primary Audience (2): ▪ VCT health providers for HIV and STIs	Capacity development in counseling for HIV and STIs	Group counseling Mass media	Counseling skills and priority messages
			Secondary Audience: ▪ Peers, sexual partners ▪ Parents, members of cooperative, VCT health providers for HIV and STIs	Community mobilization	Community events/ dialogue edutainment Social marketing	Facts on HIV Importance and benefit of knowing one's HIV status Peer support skills
			Tertiary Audience: ▪ Community leaders, leaders of FBOs, health providers	Advocacy	Mass media, community events/dialogue Advocacy meetings using job aids	Available quality counseling and youth friendly service
Community members stigmatize and discriminate PLHIV	HIV infection is associated with sexual promiscuity;PLHIV are seen as "dirty" Insufficient knowledge on HIV transmission	Community members should accept and support PLHIV	**Primary Audience:** ▪ Parents, peers, co-workers; neighbors	Interpersonal communication	Mass media Door-to-door Peer education	Key info on HIV and misconceptions; benefits of disclosure
			Secondary Audience: ▪ CHWs, health services providers	Community mobilization Social marketing	Community dialogue edutainment	Quality service Case management
			Tertiary Audience: ▪ Leaders, CSOs, NGOs	Advocacy	Mass media, community events	Advocate for community integration and inclusion

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
6. TUBERCULOSIS (TB)						
Suspected TB infected persons and members of their families do not seek early testing, diagnosis and treatment	Ignorance of symptoms Low perception of risk of contamination Fear of stigma and discrimination	Suspected TB infected persons and members of their families go for early testing, diagnosis and treatment	**Primary Audience:** ▪ People with chronic cough ▪ Suspected persons	Interpersonal Communication	Face-to-face Door-to-door	Key info on TB infection and illness; benefits of early screening all family members, importance of early diagnosis
			Secondary Audience: ▪ Family members of TB Infected persons ▪ Parents, relatives, CHWs	Social mobilization, peer education, social marketing edutainment, door-to-door, community dialogue	Community outreach Social events, group counseling, mass	Key info on TB infection and illness management; benefits of early screening all family members; importance of early diagnosis
			Tertiary Audience: ▪ Leaders/authorities CHWs	Advocacy	Edutainment, social events	Put in place support mechanisms for screening
A proportion of TB infected persons with members of their families do not adhere to prescription and develop drug resistance	Long and too demanding treatment (strict respect, daily travels to health facility) Persons on treatment forget to take medication Side effects	Household members infected with TB complete prescribed dose of treatment and practice all recommended preventive behaviors (hygiene, nutrition)	**Primary Audience:** ▪ TB Infected persons	Interpersonal communication	Face-to-face Peer education Group counseling	Benefits of adhering to prescription and life style (inmates, schools, men in uniform)
			Secondary Audience: ▪ Parents, relatives, CHWs, school, communities	Community mobilization Social marketing	Community outreach/ events, group counseling, edutainment	Sensitization on active detection of TB in community Support TB patients; address stigma
			Tertiary Audience: ▪ Leaders/authorities	Advocacy	Conference, social events, community dialogue	Advocate for quality care and services and products

PROBLEM BEHAVIOR	CAUSES	BEHAVIOR TO PROMOTE	AUDIENCE	COMMUNICATION COMPONENT/ INTERVENTIONS OR APPROACHES	POSSIBLE CHANNELS	KEY CONTENT FOR MESSAGES/TOOLS DEVELOPMENT
7. SEXUAL AND GENDER-BASED VIOLENCE (SGBV)						
Overall Objective - SGBV: To increase awareness on importance of reporting cases of SGBV and seeking support						
Sexually or physically abused women or girls do not report cases and do not seek counseling and support	Fear of stigmatization Limited knowledge on laws against GBV Limited knowledge on existence of psychosocial support services	Every abused woman or girl reports the abuse/rape and goes for comprehensive care (testing, PEP, Emergency Contraceptive Provision [ECP], counseling, treatment, psycho social and legal support as well as reintegration).	**Primary Audience:** ▪ Girls 10–18 ▪ Women aged 19 and above	Interpersonal communication Peer education	Mass media Radio serial drama Peer education Group counseling	Key information of what is sexual abuse, communication skills, law on gender-based violence
			Secondary Audience: ▪ Male sexual partners, parents, relatives	Community mobilization Social marketing	Community/social events, group counseling, mass media, anti GBV clubs, edutainment	Counseling skills Managing cases and psycho-social support Create awareness on norms
			Tertiary Audience: ▪ Leaders/authorities at respective levels, men's associations, women's associations	Advocacy	Conference, social events, community dialogue	Advocate for support interventions, quality care and products for case management: PEP kit at one-stop center and in any health center

APPENDIX 2. SBCC PARTNERS' (17) MAPPING OF MNCH-RELATED ACTIVITIES BY DISTRICT

		ORGANIZATIONS																		
DISTRICT		MoH	ADRA	CCP/ JHU	CHF Int	EGPAF	EIP	FAM	FHI 360	Intra Health	PSI Rd	Jhpiego	JSI Rd	MCHIP	RBC/ RHIDPC	RB/ RHCC	Swiss Coop	UNFPA	UNICEF	WHO
1	Nyarugenge																			
2	Gasabo																			
3	Kicukiro																			
4	Rulindo																			
5	Gakenke																			
6	Gicumbi																			
7	Musanze																			
8	Burera																			
9	Rubavu																			
10	Rutsiro																			
11	Ngororero																			
12	Nyabihu																			
13	Karongi																			
14	Nyamasheke																			
15	Rusizi																			
16	Kamonyi																			
17	Kayonza																			
18	Ruhango																			
19	Nyanza																			
20	Huye																			
21	Gisagara																			
22	Nyamagabe																			
23	Nyaruguru																			
24	Nyagatare																			
25	Gatsibo																			

		ORGANIZATIONS																		
DISTRICT		MoH	ADRA	CCP/ JHU	CHF Int	EGPAF	EIP	FAM	FHI 360	Intra Health	PSI Rd	Jhpiego	JSI Rd	MCHIP	RBC/ RHIDPC	RB/ RHCC	Swiss Coop	UNFPA	UNICEF	WHO
26	Kayonza																			
27	Rwamagana																			
28	Ngoma																			
29	Bugesera																			
30	Kirehe																			

APPENDIX 3.SBCC PARTNERS' (17) MAPPING BY HEALTH INTERVENTION (28) (NOTE: DATA AS OF NOVEMBER 2011)

		ORGANIZATION																		
	ISSUE	MoH	ADRA	CCP/ JHU	CHF Int	EGPAF	EIP	FAM	FHI 360	Intra-Health	PSI Rd	Jhpiego	JSI Rd	MCHIP	RBC/ RHIDPC	RBC/ RHCC	Swiss Coop	UNFPA	UNICEF	WHO
1	HIV & AIDS																			
2	SRH																			
3	PMTCT																			
4	Pediatric																			
5	VCT																			
6	ART																			
7	Malaria																			
8	Family Planning																			
9	Child Survival																			
10	IMCI-Facility																			
11	IYCN																			
12	Breastfeeding																			
13	MCH																			
14	Immunization																			
15	Nutrition – Food Security																			
16	Tuberculosis																			
17	SGBV																			
18	Environmental Health																			
19	Hygiene and Sanitation																			
20	Cervical Cancer																			
21	MNCH																			
22	OVC																			

	ISSUE	ORGANIZATION																		
		MoH	ADRA	CCP/ JHU	CHF Int	EGPAF	EIP	FAM	FHI 360	Intra-Health	PSI Rd	Jhpiego	JSI Rd	MCHIP	RBC/ RHIDPC	RBC/ RHCC	Swiss Coop	UNFPA	UNICEF	WHO
23	Palliative Care																			
24	Psycho-Social Support																			
25	Economic Strengthening																			
26	Population & Development																			
27	Gender																			
28	Rights																			

APPENDIX 4. LIST OF REFERENCES AND RESOURCES

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