

# MotherCare™



## Applying Social Marketing to Maternal Health Projects

*The MotherCare Experience*



*The Manoff Group*

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Marketing to Maternal  
Health Projects***

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Experience***

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# ***T***able of Contents

<b>What to Expect from This Guide</b> .....	iii
<b>Part I:</b> Social Marketing: An Orientation .....	1
<b>Part II:</b> Formative Research: Recommendations, Questions and Answers .....	15
<b>Part III:</b> Country Project Profiles .....	41
Bangladesh .....	43
Bolivia (Cochabamba) .....	55
Indonesia (Indramayu) .....	67
Indonesia (Tanjungsari) .....	81
Kenya .....	93
Nigeria .....	103
The Philippines .....	111
<b>Part IV:</b> Back to Basics .....	121

## ***What to Expect From This Guide***

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This guide is designed for social marketing, health communication and information, education and communication (IEC) specialists, maternal health program managers and researchers. It is meant to convey the process, products and lessons learned from designing and implementing social marketing activities and their health communication components under MotherCare. It is not a “How to...” manual but rather a revelation of ways and means to better influence and affect behavior in the context of maternal health programs.

There are four major parts to this guide:

### ***Part I: Social Marketing: An Orientation***

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This discussion introduces the reader to social marketing—how its strategies fit into an overall maternal health program and how its promotional and educational component (health communications) plays a major role in affecting behavior:

#### **A. Affecting Behavior: What Does This Entail?**

Behavior change is as complex as the motivating, inhibiting and enabling factors that shape, temper and harden behavior over time. Interventions meant to redirect or reinforce those factors which form people's health care-seeking and health care-giving behaviors must be multi-faceted. Health communications, management and supervision, clinical skills training, policy, protocols, legislation, equipment and supplies, and research make up the gamut of interventions that interdependently or in combination can affect behavior.

#### **B. Behavior Change's Goal: The Movement Toward Health**

It is natural for pregnant women to seek comfort when sick or in pain. And it is not novel for health workers to strive for a more positive work environment which allows them to deliver quality care. These two quests are interlinked; mutually inhibiting, enabling and motivating, one action needs the other to achieve its goal. Neither client nor provider can break free from discomfort without mutual progress.

#### **C. How to Facilitate a Mutually Beneficial Health Care System**

Programs should be designed not only to cater to the health care needs and perspectives of women, but to share the responsibility for behavior change among familial and community supporters and their health care providers.

#### **D. Social Marketing and Health Communication Experiences and Lessons Learned**

The health communication component of social marketing programming is made up of several distinct phases, from formative research, to strategy development, implementation and project management, monitoring and, finally, evaluation. Several lessons from MotherCare's experience are given to strengthen future maternal health program designs.

## ***Part II: Formative Research: Recommendations, Questions and Answers***

In this part, the importance of formative research and recommendations for designing, implementing and analyzing focus group discussions and in-depth interviews are explored as they relate to maternal health.

A menu of question areas on several maternal health topics and examples of anecdotes and answers to those questions from MotherCare project research is presented along with a bibliography.

## ***Part III: Country Project Profiles***

The countries where social marketing and health communication activities were conducted are highlighted: Bangladesh, Bolivia (Cochabamba), Indonesia (Indramayu; Tangjungsari), Kenya, Nigeria, and the Philippines. Each profile contains three segments:

- A narrative containing a description of the project in each of its phases:
  - formative research
  - strategy formulation and development
  - implementation and monitoring
  - findings and future directions
- Examples of health communication materials
- A bibliography of pertinent social marketing and health communication reports, working papers and articles produced under MotherCare.

## ***Part IV: Back to Basics***

This part highlights major objectives, audiences and messages to properly address a variety of maternal health topics through a social marketing and health communication component.

***What follows is by no means a complete accounting of MotherCare social marketing and health communication activities. It is meant to be, however, a substantial step in guiding maternal health programs to take a much more integrated approach in changing behaviors of clients, their enablers and their health care providers.***

# ***P***art I

## ***Social Marketing: An Orientation***

### ***Introduction***

***Social marketing is the application of marketing principles to social program design and management. It is a systematic approach to solving problems related to the adoption of health-promoting behaviors such as enhanced utilization of services, trial and continued use of a product, and improvement of household or community practices. Because it is an approach and not a solution, there is no program template for others to copy...***

***Social marketing provides a voice for the consumer—the program beneficiaries—and is concerned with their perspectives and practices and making it easier for them to follow better practices.\****

Part I introduces the reader to how social marketing fits into an overall maternal health program and how health communications—its promotional and educational component—plays a major role in affecting behavior.

### ***Affecting Behavior: What Does This Entail?***

The array of knowledge, feelings, attitudes and perceptions that make up a person's behavior is shaped and hardened by its environs. Activities and interventions meant to redirect or reinforce people's health care-seeking and health care-giving behaviors must be as multi-faceted as the behaviors they are designed to affect and change.

With regards to maternal health, the responsibility of behavior change is not restricted to the pregnant woman but must be shared among her supporters (e.g., her family and community) and providers, whether traditional or formal, and the medical network in which they work. Nor is there one intervention that can solely take credit or blame for rendering behavior change. A client motivated (through a health communication campaign) to avail herself of a nearby clinic (due to an improved services project) may find the clinic lacking services of a midwife (a management/supervision or even policy issue). Or the pregnant woman may find a health worker who, although present, is allowed only to perform certain functions (possibly a policy issue) which will not satisfy the client's needs. Perhaps the drugs needed to treat her will not be in stock (a logistics/supplies issue). And many times the behavior of the service provider (a training issue) toward the client is neither motivating nor enabling, but hostile.

\* Excerpts from a speech given by Marcia Griffiths, President of The Manoff Group, at the 43rd Anniversary Scientific Meetings of the Institute for Nutrition of Central America and Panama (INCAP), Guatemala City, Guatemala, 7-11 September 1992.

Social marketing is a strategy that attempts to link behavior change with intervention. Its foundation for changing clients', their supporters' or their providers' behaviors is based on the knowledge, feelings, attitudes and perceptions of those clients, supporters and providers. The underlying tenet is that the clients themselves must participate in designing optimal solutions that also meet technical criteria for desired impact.

Social marketing also relies on the marketing principles of price, product, promotion and placement to affect behavior change. These principles can be translated into familiar public health terms of availability and cost (price), quality of care (product), health communications (promotion), and access of products/services (placement).

Social marketing's recommendations for redirecting and reinforcing behavior are therefore meant not only for developing health communications, where it is usually applied, but also for strengthening training, enhancing policy and improving service delivery.

Health communications comprises the activities surrounding the promotion of behaviors, services and products through an appropriate mix of mass media (electronic, print and traditional), interpersonal communication (counseling) and community-based promotional campaigns.

The following three narratives describe behavior change as a movement by client and service provider toward a mutually beneficial health care system and how, in the context of social marketing, health communications plays a key role in affecting behavior.

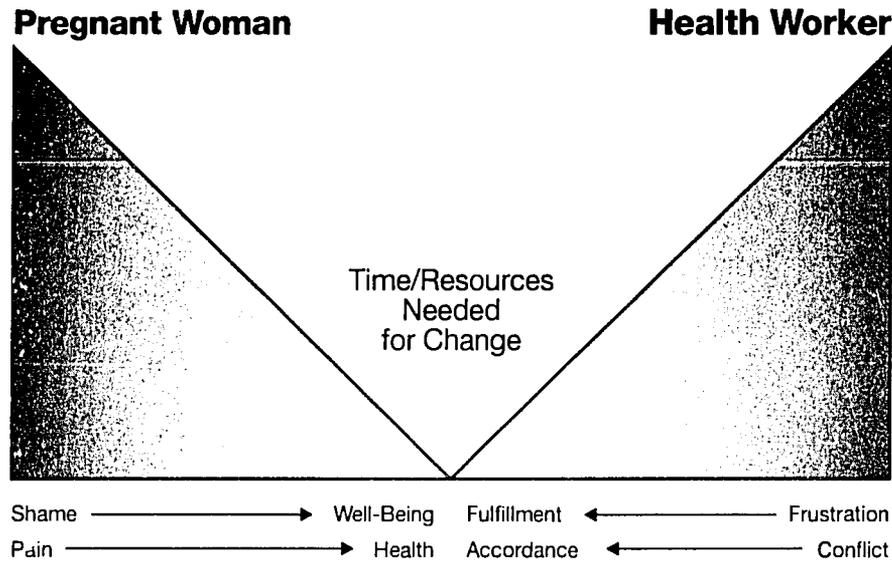
## ***Behavior Change's Goal: The Movement Toward Health***

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It is natural for pregnant women to seek comfort when sick or in pain. And it is not novel for health workers to strive for a more positive work environment which allows them to deliver quality care. There are several self-care health behaviors a pregnant woman can do on her own, such as eating more nutritious foods or avoiding physically strenuous work. But these two quests to receive and give quality health care are interlinked; mutually inhibiting, enabling and motivating, one movement needs the other to achieve its goal.

Safe motherhood is based on self-care health behaviors as well as this movement toward an interaction between a pregnant woman seeking assistance and the health provider who can provide a variety of prenatal, intrapartum and postnatal care, especially obstetrical emergency services. However, the pregnant woman and the health provider operate in different environments that often are not compatible.

For the pregnant woman, her environment is imbedded in tradition, religion, social structures, and physical location which inhibit, enable or motivate her health care-seeking behavior. For the health care provider, there are two environments. Her personal environment may have similar or different social, ethnic and religious parameters than her client's, diminishing or heightening the quality of interaction between client and provider. And the professional environment—one of standards, norms, protocols and program incentives and disincentives—is shaped by medical hierarchies, infrastructural adequacies, social status and other inhibitors, enablers and motivators to providing care. These environments and the movement toward interaction of a pregnant woman and her health care worker are visualized below:



### Horizontal Axis

The horizontal axis represents a continuum of seeking comfort for the pregnant woman within her environment and the health care provider within her/his environment. Comfort is an individual's own perception, but it is shaped by societal, religious and practical values.

In many societies, cultures and religions, for a woman to express or succumb to pain is shameful; silent self-sacrifice is preferred. The recognition of a medical problem is shrouded in denial because pain experienced during pregnancy is thought to be universal and therefore must be stoically endured. Typically, this high degree of shame persists where women are isolated not only from medical services, but also within their own culture and society.

If there is an urge to seek comfort from signs, symptoms and pain experienced during pregnancy and delivery, it is also suppressed by not knowing what to do or having no knowledgeable, empathetic or accessible person or place to go to for help. But as these barriers are broken down, the pregnant woman begins to and is motivated to seek a higher level of comfort and health. And because this higher level is also the *raison d'être* of the health worker, the search brings client and provider closer together.

The health care provider faces similar discomforts brought on by a clash between the promises of what is offered by "modern" medicine and the reality in which it must be practiced. Their most uncomfortable area is where skills and roles are under- or wrongly utilized and frustration with the system is high due to lack of supervision, inadequate remuneration and supplies, ineffectual referral networks and a clientele that appears, from the health care provider's view, unconcerned with their own health needs, even though their needs may be overwhelming.

Clients are also the source of conflict for health care providers. Many pregnant women don't do what the health care provider would like them to do. When non-compliance proves fatal, frustration is magnified for the health worker because death is in conflict with what health workers are supposed to strive to provide.

Because health workers are sometimes isolated from supplies, supervision and skills, the practice of managing emergencies conflicts with written protocols. Total quality health care

becomes a distant goal to strive toward. Add to this scenario differing ethnic, religious or social backgrounds between the client and the provider, and a health care service can be a sometimes hostile place to seek and provide care.

Movement toward comfort for the health worker is dependent on the client and the medical network. The health worker and her/his environment must move closer toward providing a quality of care that fulfills the professional goals of the health worker and is in accordance with the medical network and the client they are serving.

### **Vertical Axis**

The vertical axis shows the intensity of time and resources needed to realize movement from discomfort to comfort (albeit the types of resources differ as movement progresses along the continuum). The more entrenched women and health workers are in "discomfort" areas, the more time and resources are needed to overcome the inertia of behavior change. Similarly, the closer women and health workers are to their comfort zones, the more inertia is replaced by client and provider interaction that itself continues the movement.

## ***How to Facilitate a Mutually Beneficial Health Care System***

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Several tenets have been identified to facilitate the timely and life-saving movement of the client toward receiving health care and the health worker providing quality care. Social marketing and health communications play important roles in promoting this movement.

### **Moving the Focus**

Programs designed to have an impact on the health of a pregnant woman should be founded on reinforcing or redirecting the traditional and biomedical factors that shape and reinforce the knowledge, attitudes and behavior of the pregnant woman and the medical establishment.

To better understand and appreciate these factors, formative research is conducted. Quantitative research identifies prevailing patterns of coverage, compliance and outcomes. But it is qualitative research that reveals the reasons behind behavior. It is the latter which forms the basis of health communication messages and media designed to affect that very behavior of both client and provider.

### **Moving the Responsibility**

Behavior change is everyone's responsibility and should be shared by the primary client (the pregnant woman), her family, her community supporters and decision-makers, and her traditional and formal medical network of health care providers (and *their* decision-makers).

Formative research and experience shows that many of the motivating, enabling and inhibiting factors shaping the behavior of a pregnant woman are out of her control. Whether it is her culture or religion, her husband or mother-in-law or the service provider she must seek for help, these influences need to be addressed directly. Health communications focuses not only on the pregnant woman as the primary intended audience, but also provides

messages to affect the behavior of those who strongly influence her behavior.

## Moving the Services and the Pregnant Woman

In addition to self-care, the health of a pregnant woman relies on her own and her supporters', providers' and decision-makers' abilities to recognize, make and act upon timely decisions to have access to and utilize routine and emergency care.

Within her community, a pregnant woman can start at practicing self-care and move to a higher level of care by seeking preventative and emergency care from traditional healers and birth attendants. Health communication informs her of healthy practices but also helps her to recognize when additional care needs to be sought, and where.

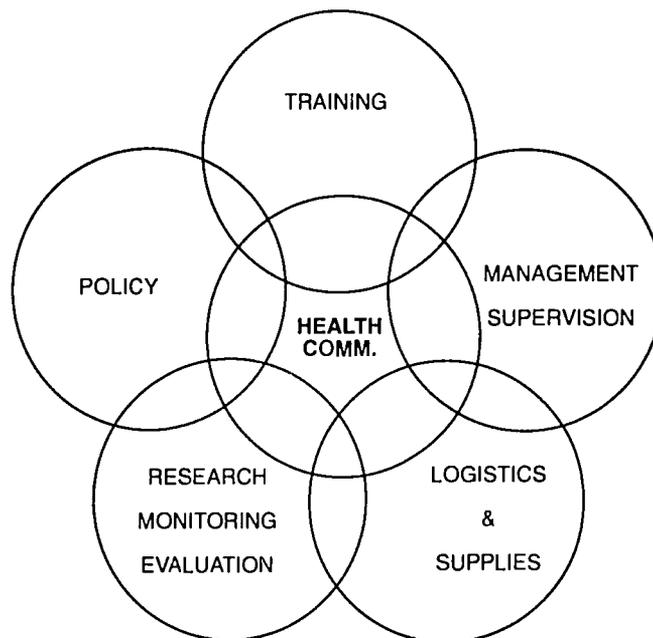
Once beyond self-care, a pregnant woman should be able to be properly referred from traditional to primary through secondary to tertiary care. This referral depends on the movement of the medical network towards the pregnant woman, either by establishing community-based services through outreach and obstetrical emergency care offered within her community, or by making accessible counseling, preventative and curative care outside of the community through regular or emergency means. Social marketing helps address training, policy and service delivery issues as well as develop health communication activities that make these services more amenable to use by the client.

## Moving Through Priorities

Maternal mortality is much less common than maternal morbidity, but its impact on quality of life (and death) is undeniably severe and definitive. Should resources address the maternal mortality side of programs—recognizing and responding to danger signs and obstetrical complications—or should projects focus on pre-pregnancy, family planning, nutritional and prenatal care which affects women's health but is questionable (except for family planning) in directly saving pregnant women's lives? Or is there an effective middle ground?

## Moving Among Interventions

Program activities meant to enhance service delivery should be designed to be as integrated as the components that make up service delivery's quality of care. Six major components are identified and visualized at right in an integrated fashion:



Enhancing one component is dependent on ensuring other linked components are strengthened as well. Health communications has a role to play or a need to fulfill by being integrated with other interventions. The link with training is clearly seen through interpersonal communication activities like counseling. Similarly, management and supervision of staff will ensure that counseling, distribution (through logistics and supplies) and other uses of health communication materials and activities (like community outreach) are performed as best they can be. Policy depends on health communications to better disseminate findings and to advocate for change among the medical and non-health strata of society. And research, monitoring and evaluation play key roles in determining the appropriateness and effectiveness of health communications in affecting behavior.

### **Move Towards Practical and Lasting Change and Impact**

Institutionalize change by institutionalizing program design and implementation into existing local agencies and organizations. This is especially necessary to instill the perspective, philosophy and practice of social marketing and health communications into the daily routines of health program managers. Appreciating the needs and perspectives of clients when designing activities meant to benefit them need not only apply to the interaction between client and provider. Interpersonal communication skills are also important tools to enhance the supervisor-service provider relationship.

## ***Social Marketing and Health Communication Experiences...***

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Following are examples of how social marketing and its health communication components of seven country projects were implemented to affect behavior and the movement toward health. Details of the formative research, subsequent health communication activities, and a summary of general objectives, behaviors and messages emanating from these activities are found in Part II ("Formative Research: Recommendations, Questions and Answers"), Part III ("Country Project Profiles") and Part IV ("Back to Basics") of this guide.

### ***Bangladesh***

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Formative research at the beginning of this project showed the need for pregnant women, their families and their communities to be much more aware of maternal self-care activities. Findings also showed the need to improve access to obstetrical emergency care since the nearest hospital was virtually inaccessible to the community.

Midwives were therefore introduced at the community level as the first source of treatment for obstetrical emergencies. Motivational print materials were developed for use by social workers with pregnant women, their husbands and their mothers-in-law to: (1) promote self-care behaviors such as eating more nutritious foods, avoiding physically strenuous work, resting more, preparing for a safer, cleaner home delivery, and caring for the newborn infant (warming and breastfeeding); and (2) promote timely routine and emergency prenatal care at the community-based clinics staffed by midwives. This project also strengthened the link between traditional birth attendants (TBAs) and community-based midwives by training the TBAs and encouraging them to accompany their client to the clinic and to review their cases with the midwife in attendance.

## ***Bolivia (Cochabamba)***

Formative research revealed disparities between what the medical community and what pregnant women considered to be quality of care at the clinic and hospital level. Edema, for instance, was considered by pregnant women to be a common and therefore harmless occurrence, but a cause for immediate concern by health care workers. Also, whereas hospital deliveries were usually attended by several different medical professionals, including interns, pregnant women were adamant about their privacy.

Five phases of health communication activities were designed for policy-makers, pregnant women and health care providers: advocacy for maternal health care and the quality of that care according to the perspective of the pregnant woman; prenatal care; clean and safe delivery; postpartum and postnatal care; and family planning. Medical supervisors were oriented to the perspectives of pregnant women and ways in which services and their staff could better meet their clients' needs; health care workers were given counseling training in each of these phases as part of this effort.

The urban setting of this project merited heavy use of television and radio. Clinic-based flipcharts and community-based participatory activities complemented the electronic media. The use of *vox populi* (voice of the people) as a style in the television and radio spots to ask questions about danger signs had a significant effect on the audience's behavior in asking the same questions of their service providers.

## ***Indonesia (Indramayu)***

Formative research gave insights on why consumption of iron folate tablets was low in the area. Limited access to sources of tablets and side effects after taking tablets (such as bad aftertaste and constipation) were primary reasons for low coverage and compliance in taking iron folate tablets on a daily basis.

A control area, focusing only on government clinics as a distribution point, used a health communication campaign of radio spots; banners and community-based activities; clinic-based posters and "iron tablet day"; and a flipchart used by midwives, TBAs and health workers promoting the importance of iron tablets, how to take them, possible after-effects, and where to get more. A common character, phrases, images and audio jingles were used to link the variety of messages and media together.

A similar but experimental area introduced a new distribution system (having TBAs give out iron folate tablets) in addition to the government service. This new system was followed nine months later by the health communication campaign used in the control area. Repackaging of iron folate tablets was also a key intervention; product testing with pregnant women showed that tablets were turning from a white color to grey as well as crumbling when left exposed in an unsealable plastic bag.

## ***Indonesia (Tanjungsari)***

Community-based birthing huts (*Polindes*) were introduced into communities with the intent of providing prenatal care and linkage by two-way radio and ambulance to obstetrical emergency facilities for complicated deliveries. Formative research was conducted after birthing huts were in place and revealed the need to change the structure, placement and services of the birthing huts as a key to affecting the behavior of clients.

The health communication campaign focused on promoting, through the distribution of leaflets and community-based activities (e.g., parades, contests of knowledge among TBAs, "open house" days at the birthing huts where ambulance and two-way radio service was demonstrated), use of the huts among pregnant women, their husbands, their traditional birth attendants and the community at large.

## ***Kenya***

Formative research indicated two major inhibitors to seeking and providing quality care regarding the prevention of congenital syphilis:

- Syphilis screening procedures were separated by time and distance from syphilis treatment procedures. Pregnant women had to wait no less than one week for test results to be returned from a central lab and then had to seek treatment at a different health facility.
- Interpersonal communication between a health care worker and a pregnant woman attending prenatal care, and between a pregnant woman and her partner hampered the exchange of information about syphilis, its treatment and prevention from reinfection.

A new screening procedure (RPR test, or Rapid Plasma Reagin) was introduced at the clinic and shortened to no more than two hours the time it took for pregnant women to learn if they tested positive for syphilis. Treatment was immediate.

Interpersonal communication skills, counseling cards and take-home leaflets were at the center of this project's health communication component. Prenatal care providers were given counseling training to reduce the hostility felt by clients in getting services and addressing values issues in serving people with sexually transmitted diseases. Counseling cards for use by service providers were developed to assist pregnant women infected with syphilis to negotiate and agree upon (1) a realistic behavior for them to follow regarding treatment and avoiding reinfection; and (2) notifying and bringing in their partner(s) for treatment. Take-home leaflets were also developed and distributed to pregnant women and their partners to promote compliance to treatment and prevention of reinfection.

## ***Nigeria***

Formative research showed that communities were basically unaware of available midwifery services. Health care workers' interpersonal communication skills at these facilities were in need of strengthening as they hindered demand for the services once the community realized of its existence.

Clinical life-savings skills workshops, provisions of equipment and supplies and a supportive management policy will all be part of the integrated approach to affecting the behavior of the health care worker. The health communication component includes an interpersonal skills workshop for health care workers and will employ a creative mix of mass media and community-based activities to promote the use of clinics and its midwifery services.

## *The Philippines*

Formative research showed a need to upgrade midwifery clinical case management skills. In support of the subsequently developed midwifery manual of standards and practices, health communication materials for midwives were developed to promote a better understanding of the use of clinical case-management flow diagrams. Counseling was also introduced as a life-saving procedure in case management.

Client-oriented print materials for TBAs and pregnant women promoting prenatal care attendance and recognition of danger signs during pregnancy were developed and will be distributed through counseling sessions.

## *...and Lessons Learned*

***Each of the health communication components mentioned above have similar roles in the context of social marketing to enhance both client and provider movement toward health-promoting behaviors. Health communications can:***

- inform and motivate clients and their supporters to use appropriate self-care, such as consuming more nutritious foods or recognizing risk factors and danger signs;
- increase coverage of particular health services, facilities and products by improving awareness of its access or distribution points and making its use better understood and more desirable;
- strengthen the interaction between health provider and client, and among health providers themselves; and
- ensure a degree of compliance by informing people about the benefits of the service or product, the importance of timely and continuing use or consumption, and alerting them to the consequences or side effects of continuing consumption (or non-consumption).

The life of a health communication component can be broken into five major areas of activity: formative research, strategy development, message/media development and implementation, monitoring and evaluation, and program management (which is found in each of the other areas of activity as well). Although each activity follows its own process, the success of health communication and social marketing interventions depends on the competent implementation of all steps and the ability of program managers to refine interventions based on gradually increasing insights during the entire process.

### **Formative Research**

Formative research includes quantitative research in the form of surveys and clinic data but emphasizes qualitative research that probes into the rationale of people's behavior. The former sheds light on what trends and patterns exist in health care-seeking and -providing behavior. The latter reveals why.

Unless the behavior is known and understood, it cannot be changed. That is why formative research forms the bedrock of social marketing and health communication programs.

Focus group discussions, in-depth individual interviews, concept/product testing (observing the use of a product or a service over a limited time period to test whether a redirected or reinforced behavior is realistic) and open-ended questions posed to clients, their supporters and health care providers form the core of qualitative research. It highlights the behaviors that motivate, enable and inhibit movement toward health.

***Specific lessons learned in designing and implementing formative research are contained in Part II of this guide. In general:***

- Formative research should be designed, conducted and analyzed within an overall research, monitoring and evaluation framework or plan.
- Qualitative and quantitative research should be timed to build on each other's findings.
- The question areas of formative research should be similar to those of monitoring and final evaluation activities. By doing so, research results can be more easily compared and behavior change can be revealed over the time period of the project.
- Unless project teams have a vested interest in becoming adept at conducting formative research, seek expert help to facilitate its design, implementation and analysis.

## **Strategy Development**

Based on research results and the variety of political and health priorities shaping a country project or program, a comprehensive maternal health program strategy is formed.

Objectives, intended audiences and activities are identified in the areas of policy, clinical training, management and supervision, equipment and logistics and health communications. A framework for monitoring and evaluating the activities should be inherent in the strategy. And a realistic budget, time frame and technical assistance schedule should be formulated.

Many times, though, formative research—because it forms the crux of a health communication strategy—is neither designed nor used to develop strategies that shape other components of a program. For instance, focus groups with clients will reveal a lack of interpersonal skills on the part of service providers, and so part of a health communication component would include counseling training. The same research, however, reveals the vagaries of providing services without adequate supplies, supervision and motivation; yet no management/supervision intervention may be forthcoming.

***Strategy development must be more integrated. In summary, lessons learned include:***

- Keep behavior change at the forefront of any strategy.
- Use formative research not just for health communications but to guide the reshaping of services, including training, management and supervision, policy and equipment and supplies.
- Orient project teams and their supporters and enablers to strategy development through workshops that allow them to examine formative research results and develop strategies that they will feel capable of and support implementing.

- Ensure, in the development of strategies, that service providers are represented in designing activities that promote (and/or improve) their own services.
- When scheduling and sequencing activities and interventions, allow any newly created or improved distribution system to run its course and then re-examine its utility and effect on client knowledge, attitudes and behavior before finalizing a promotional activity for the “new” service or product.
- Whenever possible, practical and appropriate, stagger the time and resources needed to develop messages and media and to conduct health communication campaigns to avoid overloading the capabilities of the project team and the ability to absorb messages by the intended audience. Staggered implementation also allows for better use of monitoring results to readjust activities.
- Even when under pressure, try to develop a realistic time frame, appropriate quality and quantity levels of messages and media, and budget.

## Message/Media Development

This stage brings to focus the communication component. It is when creativity, innovation, practicality and appropriateness converge to develop messages and to select the media. Rounds of pretesting are mandatory to ensure that messages as well as the behaviors being promoted are palatable, realistic and acceptable. Among the lessons from the MotherCare experience are the following:

- Distribute health communication print materials to clinics or communities by introducing them through counseling or adult education refresher/in-service training to health or social workers.
- Identify minimum quality standards for print, video and audio media materials based on existing technical and creative resources and the comparative quality of other media already being distributed or broadcast.
- Make pretesting vigorous and on-going throughout the life of the project, particularly when developing messages and materials and when monitoring the initial and subsequent stages of implementation.
- Appropriately balance mass media, community-based promotional activities and interpersonal communication (e.g., counseling) to ensure that the client gets the message frequently and when it is needed.
- Link messages and materials in a campaign by common images, characters, words and phrases (e.g., posters illustrating a main character and repeating phrases from a radio spot).
- Ensure that messages:

**define abstract medical terms** (e.g., “normal,” “risky,” “problem,” “timely,” “pain,” “bleeding”) with verbatim words used by and familiar to clients;

**are action-oriented** (e.g., if you experience this symptom, then you should do this specific action);

***negotiate an agreed-upon, realistic behavior before the intended audience leaves the venue of the message (e.g., turns off the radio; leaves a counseling session);***

***are culturally appropriate; and***

***are concise and memorable.***

- Make interpersonal communication skills workshops (i.e., counseling) a part of virtually all health communication components. These skills address the crucial interaction between client and service provider and focus on affecting health worker behavior. Workshops also raise morale, can be a distribution point for health communication materials, as well as reveal needs for other interventions (e.g., management and supervision) to improve service delivery.
- When possible and practical, focus on one key or critical or life-saving element of maternal health (e.g., iron folate tablets; recognition of danger signs and where to go; counseling) rather than dilute resources, efforts and messages with the whole array of maternal health care behaviors (see Part IV for further details of what that array is).
- Appreciate and quickly address the possibility that self-esteem may be gained or lost by different health care workers in the following situations:

***Using health communication materials:*** these are meant to improve the quality of service by health care workers. But in Indonesia (Indramayu project), some midwives felt that print materials meant for them to use with their clients during counseling sessions actually revealed to the client how little the midwife knew because she had to use educational aids.

***Complying with referral:*** proper case management of danger signs and complications, and especially referral to emergency care facilities, saves lives. But in Indonesia (Tanjungsari), TBAs hesitated to comply with referring their clients to higher levels of care because they thought their clients felt that referral was a sign that their TBA could not “handle” an emergency situation.

***Improving interpersonal skills:*** good counseling is a key component of quality care. But counselors may feel placed in an awkward and uncomfortable situation serving people they generally don’t associate with outside of the clinic and health setting.

## **Monitoring and Evaluation**

Monitoring activities assess the process and progress of the program in terms of implementation—whether deadlines are being met and resources are being properly utilized.

Monitoring also keeps track of changes in knowledge, attitudes and behavior specified in the messages of the campaign while taking into account other project-related activities (e.g., increased cost of services) and unrelated events (e.g., economy, weather) which may have a bearing on how the messages are being received and reacted to.

- Qualitative and quantitative monitoring is vital. It should be designed and planned for during the strategy development phase after it is clear what precisely is to be measured. It should be initiated well before health communication messages are introduced in order to obtain a starting point of knowledge, attitude and behavior change, and implemented routinely as well as based on need.

- Monitoring results should be analyzed on the spot in order to effect necessary changes to the health communication component as well as other interventions in the project.

Evaluation focuses on a program's impact. Whenever appropriate, evaluation should examine behavior change as a result of all interventions in the program, not just health communications alone. Evaluation activities should be designed, conducted and analyzed within an overall research, monitoring and evaluation framework or plan. This plan should be developed during the formative research and strategy formulation stages of the program.

## **Program Management**

Time, money, skills and human energy need to be well balanced and accounted for in order to design and implement effective programs, especially health communication activities.

### **Technical assistance:**

- Technical assistance should be consistent; sending a variety of personalities, technical biases and levels of expertise to work on one specific skill area will undermine the smooth forward progress of projects.
- Recognize the need for a variety of expertise to address the variety of technical skill areas inherent to a social marketing program and health communication component.
- Interpersonal and cross-cultural skills are as important as the technical skills being offered.
- Whenever possible, in-country consultants should be assigned to help implement and monitor the project but be supplemented by expatriate technical assistance. This will especially help in the time-intensive, repetitive, hands-on process of transferring skills.
- Technical assistance should not replace (nor be replaced by) but rather supplement skills workshops.
- Skills workshops transfer skills (e.g., formative research, strategy development, message/media design, monitoring and evaluation) and at the same time make the provision of technical assistance to the project more lasting and meaningful.

### **Project administration:**

- Orient the project staff, in-country and at headquarters, to social marketing and health communication philosophies and strategies to ensure that the process, preparation and variety of activities and resources needed are appreciated.
- Establish health communication advisory committees consisting of government, private sector, media and other non-health representation early on for strengthening advocacy and disseminating messages and media.
- Strive to apply lessons learned, innovations attempted, strategies implemented and results obtained from previous or existing projects to subsequent programs.

- Explore and strengthen alternative non-governmental organization (NGO) relationships. Programmatic links with NGOs can be a viable and enduring channel to design and implement programs and to “multiply” the process of doing so through an NGO’s other intervention sites, other country offices and other agencies in its network.
- Streamline the fiscal and reporting requirements of the project; time spent writing reports and collecting vouchers is time not spent on designing and implementing activities.

# *Part II*

## *Formative Research: Recommendations, Questions and Answers*

***Behavior cannot be changed unless it is first understood.  
This is the basic rationale for conducting formative research.***

### *Introduction*

All MotherCare social marketing projects began with formative research. Formative research refers to all research conducted as part of program design, not only to quantitative research in the form of surveys and clinic data, but also to qualitative research that probes into the rationale for people's behavior. The former sheds light on what trends, patterns and prevalences exist in health care-seeking and -providing behavior; the latter reveals why.

Part II presumes a working knowledge of qualitative research methods by the reader. Therefore, it does not detail the process of designing and formatting research plans and question guides, recruitment strategies and analysis grids. Such descriptions are found in the variety of working papers, special reports and trip reports available under MotherCare.

What follows is a brief narrative of recommendations on the conduct of qualitative formative research as it relates in general to women's health and specifically to maternal health. Then, a menu of topics and questions asked and answered across MotherCare projects is provided to give the reader an idea of the range and type of issues discussed. The realities learned from this research form the basis of the social marketing programs and their health communication interventions.

### *Recommendations for Conducting Formative, Qualitative Research on Maternal Health Topics*

Qualitative research can include focus group discussions, in-depth individual interviews, concept testing (observing the use of a product or a service over a limited time period to refine the behavior or products that will be promoted) and observations with clients, their supporters and providers to highlight behaviors that motivate, enable and inhibit their movement toward health. MotherCare used combinations of these techniques in its qualitative research.

Because qualitative research is designed to meet specific needs of programs and program situations, MotherCare's research and its implementation took many different forms:

- In Bolivia (Cochabamba), a local research agency conducted focus group discussions and interviews with women and their service providers, revealing distinct beliefs about physiology and health care practices which were either in agreement

or in complete contradiction with one another. These differences were prioritized and then addressed in subsequent health communications, training and policy interventions.

- The MotherCare/Save the Children project in Bangladesh used a six-month anthropological study of women living in Nasirnagar (the project area) that provided the insights on which to design a promotional campaign to motivate women, their families and communities to practice better self-care techniques and service utilization.
- A local consumer research company in Nigeria conducted a literature review and then focus group and in-depth interviews to create the foundation for the health communication component to promote utilization of midwifery services.
- Indonesia projects employed the services of several consultants to design and implement qualitative research on the utility of community-based birthing huts (Tanjungsari) and the consumption of iron folate tablets (Indramayu). The Kenya project followed a similar approach to study behavior surrounding congenital syphilis.
- In Jamaica, a private consumer research agency conducted focus group discussions and some in-depth interviews to determine women's preference for birthing location and attendant.
- In Inquisivi, Bolivia, Save the Children staff with village women conducted a self-assessment of their major maternal health problems.

**Several recommendations for designing, implementing and analyzing qualitative research are derived from this assortment of approaches and experiences:**

**Technical assistance:** The skills needed to appreciate, design, conduct, analyze and use formative research and its results are best transferred to projects through a combination of skills workshops, strategy or design sessions and consistent, persistent technical assistance. On-site expertise (e.g., local or expatriate professionals) assigned to implement and monitor research activities is especially beneficial.

**Research plans:** Qualitative research methods should be mixed to capitalize on the strengths of focus group discussions, individual interviews, concept/product testing and observations:

- Individual interviews with women, influencers and providers are more likely to elicit truthful and practical information about specific behavior, especially if the topic is sensitive. For example, women with delivery complications or men and women who have tested seropositive for syphilis will be more comfortable talking individually than in a group about their experiences.
- Conversely, the more common and less sensitive the issue, and the more focus the questions put on knowledge, feelings and perceptions, the more natural and interactive a group discussion may be to participants.
- Individual interviews can be more enriching if they are shaped around findings from focus group discussions.
- Concept-testing of products and services and observations of services or compliance in action can complement and help verify information obtained from interviews about behaviors.

Participants in specific focus groups should be as similar as possible to eliminate any biases that arise due to differences in ethnicity, social status or religious conviction as well as to deference based on sex, age, experience and professional status differences within the group. At least two focus group discussions per sex, age, experience or status segmentation should be conducted to provide some check on the consistency of knowledge, attitude and behavior patterns:

Sex: Mixing male and female respondents or male/female interviewers with female/male respondents will possibly stifle the openness of discussions on the sensitive topics related to maternal health.

Age: The greater the range of age within a group, the more pronounced the deference is between the younger and the older within the same group. This is particularly true with adolescents and with groups that include two generations (e.g., 19-35 year olds). In Nigeria, groups originally formed with 14-19 year olds were further segmented into groups of 14-15 year olds, 16-17 year olds and 18-19 year olds after learning that younger boys and girls with less post-pubescent experience were less talkative in front of their “elders.”

Experience: Women experiencing pregnancy for the first time will have very different approaches to prenatal and delivery care than those who have already given birth. Similarly, women who comply with a behavior (e.g., taking iron folate tablets; using prenatal care) should be interviewed separately from women who do not comply.

Status: Professionals, such as TBAs, midwives and doctors, are very competitive with one another within their own group discussions; mixing doctors and midwives (or where one set of participants may supervise the other) in one group would also yield stunted results.

Also, the beliefs and behaviors revealed may be closer to what ought to be “good health care” rather than what really is provided as “good health care” by the professionals. Individual interviews are best conducted in this situation.

Interviewers should be selected to conduct focus group discussions or individual interviews based on similar difference/deference factors. For example, midwives shouldn't interview doctors; men shouldn't interview women. Also, interviewers should be trained to do their best to tone down any differences and deference occurring within their focus group discussions.

**Topics:** Questions about recognition of danger signs, nutrition and other maternal health topics should concentrate on eliciting answers that go beyond information on knowledge and attitudes by revealing specific behaviors, their rationales, and what may motivate, inhibit or enable them to be changed.

**Analysis:** Results from qualitative research generally show that behavior and its subsequent change is shaped by forces beyond the control of the respondents. Pregnant women's behaviors are inhibited or enhanced by the behavior of their family (e.g., husband or mother-in-law), service provider (e.g., traditional birth attendant or healer; midwife) and community leader (e.g., religious, traditional). Analysis should always yield results that can and should be used to change behaviors of those exerting these forces as well. Other recommendations:

- leave enough time for analysis;

- include verbatims from interviews, as these provide a “human voice” to data and clues to possible messages;
- look for similarities in answers and then highlight differences; and
- write case studies or histories, describing typical situations and behaviors of an individual based on research data.

## Questions and Answers

During the MotherCare project, general areas of questioning were identified for use in developing question guides for qualitative research. Following are examples of areas of questioning and a summary of responses given by various audiences.

### **Question Areas About Beliefs and Practices During Pregnancy and Utilization of Care:**

- What are the attitudes of women and others about pregnancy in general? About the current pregnancy?

*Do they feel pregnancy is a special time in their lives? How?*

*What special things do women think they should do or avoid during pregnancy?*

- How do women first recognize that they are pregnant? How do they feel?

*What do they do? Who do they tell? Where and when do they seek advice, and from whom? What are their sources of social support?*

- What types of care do women perceive as necessary during pregnancy? When? For what reasons/problems? From what type of person? Why?

- What is the awareness of pregnant women/families/influentials about the need for/benefits of formal prenatal care?

*Is preventive care a recognized concept?*

*Is it common practice for pregnant women to seek prenatal care when they feel healthy? Why, why not?*

*When do they generally seek these services (how many weeks into their pregnancy)?*

- Are women aware of what should take place during a prenatal and postnatal visit (what specific medical care they should receive)?

*What do they consider “good” maternal care?*

*What terms do they use to describe quality care?*

- Is there recognition of the need for/benefits of maternal tetanus toxoid (TT) immunization? Do pregnant women take action to seek TT immunization? Why, why not?

- What have women's experiences been with formal health services for prenatal care, delivery assistance, and postpartum care?

*What are women's own perceptions of the barriers to their use of formal maternal health care (convenience, cost, need, satisfaction)?  
How could these resistances be minimized?*

*What do they like/dislike about the care?*

- Do women comply with referral for additional medical care or treatment? For which conditions? Why, why not?

## Answers:

*On going to prenatal care:* "No, because they say that at a prenatal visit they only look at your belly and your parts [genitals] and there are many men and women looking at us; that's awful; that's why I wouldn't have prenatal care."

—woman in Cochabamba, Bolivia

"I did not go to the clinic.... I get frustrated, tired to go, I feel ashamed....I had one [baby] in October and get back pregnant in December."

—woman in Jamaica

"We are not used to prenatal control visits although some women do have them; we don't attend because we are embarrassed and frightened since the health worker is a man."

—woman in Cochabamba, Bolivia

Many of the late attenders gave the interviewers several reasons why all women should come early to antenatal clinic, such as the need to make sure the baby is healthy or in the right position. Nevertheless, few of them had come for those reasons...the two recurrent themes in women's explanations of their early or late attendance were the need for the antenatal delivery card [without which they could not deliver at a public maternity hospital] and their general state of health. Women who felt well during their pregnancies did not see the need to attend the clinic.

—Kenya

About half the pregnant women interviewed felt that it was acceptable for dukun bayi [TBAs] to make home visits to deliver iron tablets, although customarily pregnant women go to the dukun bayi's home for consultation. The other half or the women interviewed expressed strong reservations about this concept, stating that the dukun bayi should not visit homes without an invitation, that such a visitor might be an "imposter" and that the tablets she carried might not be the same as those distributed through the government health system.

—Indramayu, Indonesia

Most women pay [prenatal care] visits during the fifth and the seventh months of their pregnancy, which are appropriate times to get tetanus toxoid injections. These times are also culturally more acceptable than a visit later on. Very pregnant women feel shame and do not like to be seen on roads and in public places.

—*Bangladesh*

All the staff interviewed formally and informally...expressed genuine concern for their clients' welfare. [Staff] willingness to report for work on Saturdays, when clinics are closed, just to make compliance easier for male partners, is a clear indication that, in spite of occasional shows of temper or disdain, the clinic staff are committed to a high degree of professional integrity and provision of quality care.

—*Kenya*

We were fortunate to encounter a few communities where...the clinic was a very integral part of the community, where the Nurse was a very well-respected and loved individual and where the respondents were consequently very well informed and were comfortable and positive talking about their pregnancies.

—*Jamaica*

"If there is an emergency, you must hire the whole lorry and pay around N250 to the hospital. There you pay a lot of money at the hospital. All these things we think about, hoping that they deliver successfully at home. So to prevent all these complications, we always send our wives to hospital right from the time when the pregnancy is about two months for a weekly check-up."

—*man in Nigeria*

...Common diseases are amenable to treatment at the health center, while others, like spirit possession, require services of a [traditional healer]. Formal health services offer tools, medicines, and expertise. Traditional practitioners provide familiar, nearby, and inexpensive treatments, usually in the patient's own home. Often a sick person will use both modern and traditional treatments at the same time.

—*Tanjungsari, Indonesia*

"I like the information I receive from nurses because I understand what they are saying very well. Also, these nurses are educated and they are very experienced."

—*woman in Nigeria*

"I believe in traditional health care methods because it has been before we even came to be, even in those days when there was no hospital or injection."

—*woman in Nigeria*

## Question Areas About Recognition of Problems/Risks and Response:

- What is the level of awareness of pregnant women and families toward common complications of pregnancy/birth/postpartum periods?

*What conditions during pregnancy/birth/postpartum are perceived as particularly dangerous?*

*What terms do women use to describe these conditions?*

*What is the perceived cause of each problem/risk?*

*How susceptible do individual women feel they are to each problem?*

*Why, why not?*

*How serious do women consider each problem?*

- Where do women/families get their information about pregnancy, birth and postpartum problems and risks?

- What is the level of awareness toward STDs?

*What are the different types of STDs? What are they called, how are they transmitted, what kinds of signs and symptoms appear? Do people know the relationship between STDs and HIV/AIDS?*

*What are people's beliefs about what kind of people get STDs/what kind of stigma is attached to having STDs? Do people differentiate between type of person and type of sexual behavior regarding the spread of STDs?*

*What do people think of asymptomatic diseases? Do they believe in them?*

*How are STDs prevented? What are people's attitudes and practice regarding the use of condoms? With whom do they use condoms? With spouse? partner? casual sex?*

*How do women and their partners communicate with each other about STDs? What can help them better communicate?*

- Do women/families understand the concept of obstetric risk?

*Do they distinguish between potential risk factors (age, parity, etc.) and actual risk related to current signs or symptoms?*

*Do they relate problems in previous pregnancies to the possible outcome of current pregnancy?*

- What is the sequence of actions taken for each maternal problem/risk?

*What is the first action? Self-care or other home care? Traditional practitioner, clinic, other?*

*What triggers the first action? What happens next if the problem continues?*

- What type of care for pregnant women occurs within the home prior to seeking external assistance?
- What type of practitioner do women prefer to seek care from, and for which specific pregnancy-related problems? Why?
- To what degree do women control their own self-care and use of services?
- Who else influences the health-seeking behavior of pregnant women? How?

## Answers:

For antenatal bleeding, headaches, dizziness, fever, high blood pressure, or anemia, most women would accept referral from a TBA to a midwife or go to a midwife first. Most respondents stated that swelling of feet, hands or other parts of the body is normal, and they would not accept referral for this, nor for lack of weight gain. No one thought that referral to a midwife because of small stature made any sense, nor was it regarded as a risk factor because of its predetermined nature.

—Tanjungsari, Indonesia

Kukil had been married at 17 and became pregnant a year later...Kukil was healthy for eight months of her pregnancy. Then one day she complained about severe headaches. The family did not think much of it at first. She was made to rest. A few hours later...she had fits, bit her tongue, tore off her clothes. The family sent for two [traditional healers] to treat what they believed was caused by spirit possession. As this treatment was not effective and Kukil's condition became critical, they sent for the [doctor]. He gave Kukil a sedative and recommended urgent referral to the hospital. The family did not act immediately...the husband said that Kukil died before he could organize a trip to the hospital. She died within 16 hours of developing the symptoms.

—Bangladesh

When asked to name some symptoms of syphilis or to describe how they had been feeling themselves, those women who responded gave overall coldness, painful urination and abdominal pain as their own symptoms...only a very few knew that rashes were a symptom.

—Kenya

A clinic staff member told a client she had bugs in her blood, using the Swahili word for insects rather than bacteria. The client was told to bring her husband and she went home thinking that the bugs were AIDS.

—Kenya

The non-compliers [men with syphilis]...tended to focus their responses on denial of illness...their almost unanimously sarcastic response was that if they were sick, they would have symptoms...some argued that there is no such disease as syphilis.

—Kenya

"I had severe headache; when I was pregnant, it pained me seriously but I didn't consult anybody. I only sent some children to buy "Pengo" or "Cafenol" for me from traders."

—woman in Nigeria

"Some women experience that (breaking of water more than 12 hours before labor starts). To us, it is not a sign of any sickness."

—woman in Nigeria

## Question Areas About Maternal Nutrition:

### ***Food Consumption***

- What is the pregnant/nursing woman eating now?

*How does it differ from her non-pregnant/non-nursing state? Why are changes made? Why not?*

*How does she feel—hungry? nauseous?*

- Which foods are favored or avoided during pregnancy and immediately postpartum? Why?

*How prevalent are major pregnancy-related food taboos? How helpful or harmful? How strongly held? How amenable to change?*

- What is the attitude toward pregnant and postpartum women to eating more of staple foods? of snacks?

- Do women deliberately alter the amount and nature of food consumed during pregnancy? How? When? Why?

- What are patterns of women's consumption of green leafy vegetables, yellow and orange fruits, and animal products during pregnancy and postpartum? Why? How often consumed? How much? How prepared?

- What non-foods are consumed or considered desirable during pregnancy/postpartum (teas, herbs, traditional medicines, etc.)? How frequently, how much, at which times during pregnancy? Why?

- What is the normal pattern of intrafamily food distribution? Does it change during pregnancy or postpartum? How, when, why?

- How does seasonality affect the amount and content of food consumed by pregnant women?

*How does the agricultural cycle affect women's food needs? What do women and families do to improve their diet in the lean season?*

- If iodine deficiency is a problem in the project area, why do people think it is?

*Do people know about iodized salt if available? Are they willing to consume iodized salt?*

*What are barriers to higher consumption of iodized salt or of better coverage with iodized oil injections?*

### **Weight Gain**

- Are there changes in work/activity during pregnancy/postpartum? Why, why not?

*Does the concept of the need for rest during pregnancy exist?*

*Do women/families/influentials relate women's work/physical activity during pregnancy to weight gain/loss?*

- What are women's, family's, and influentials' conceptions of ideal weight gain during pregnancy (not necessarily in pounds or kilos, but what is their image of a desirable weight gain)? Why?

- Do women feel they have control over their weight gain during pregnancy? Why or why not?

*Do they see a cause-effect relationship between their food consumption during pregnancy and the baby's birth weight?*

*Do they have any fears related to childbirth and the size of the baby?*

- What is pregnant women's understanding of the need for/benefits of prenatal weighing?

*Is there a desire/willingness to have their weight monitored? Why, why not?*

*Do women comprehend their weight when expressed in pounds/kilos or shown in a graph on an antenatal card?*

### **Maternal Anemia/Iron Supplementation**

- What is the level of awareness of maternal anemia among women and families/influentials?

*Is it recognized as a problem or considered a normal condition of pregnancy?*

*Is it thought to be a condition of concern? A common condition?*

- What are traditional concepts of the relationship between blood and health? Do these change for pregnant women? If so, how?

- Do women recognize signs and symptoms of anemia? Which ones?

*What terms do they use to describe them?*

*Do they take action to alleviate them? When, what?*

- Do women understand the relationship between maternal anemia, hemorrhage, and maternal mortality?
- Are there any existing practices during pregnancy/postpartum which could affect iron status? Which?
- Are pregnant women given iron pills?
  - Do they take them as instructed? Why?*
  - Do they return for resupply? Why?*
- What are the behavioral and attitudinal factors which influence compliance with iron supplementation?
  - What are women's perceptions of iron tablets?*
  - How would women want pills to be changed to be more acceptable (taste, color, frequency of taking, size, packaging, etc.)?*
- What is the general attitude toward pill taking?
  - Do women prefer to take medicinal pills, injections, or liquids?*
  - Does this change during pregnancy?*
  - What is available in local pharmacies?*
  - What are traditional practices?*

## Answers:

"She [health worker] will tell you to eat plenty of vegetables, things to make the baby and yourself healthy because you will need a lot of blood."

—woman in Jamaica

Doctors and bidan [midwives] agreed that despite its prevalence, they do not consider anemia a program priority. Priorities are increasing the demand for prenatal care and, among midwives, increasing safe, attended deliveries.

—Indramayu, Indonesia

The nurturing role of women, which is expected to be carried out regardless of the food they eat and at the expense of their own health if need be, was most strikingly expressed during the month of Ramzan [Ramadan] when pregnant and breastfeeding mothers of small babies identified as malnourished were fasting unflinchingly. The only legitimate excuses for Muslim women not to fast are said to be the pollution of their bodies during menstruation, during the forty days following birth and, possibly, nausea and vomiting in the first months of pregnancy which are considered to spoil the fast. Otherwise, mothers have a special responsibility to fast, precisely because they are mothers entrusted with the life and well-being of their husbands and children.

—Bangladesh

*On anemia:* "The woman's got no blood and she can die; the newborn is very thin, the mother can die during labor; it occurs because we eat very little during the first days of pregnancy and our husbands haven't had a good yield in the field."

—*woman in Bolivia*

Postpartum food proscriptions severely restrict the mother's diet. In the house of seclusion where she lies for five to nine days after giving birth, the woman is encouraged to eat and drink little. She should eat "dry" foods and once a day rice with fried turmeric and onions. Fish, meat, eggs, normal "torcari" with chilies and most vegetables are believed to be inappropriate or dangerous.

—*Bangladesh*

"I eat only 'tuwo' and 'buka' soup because I have no means of getting anything apart from it."

—*woman in Nigeria*

"When a woman is pregnant, we don't allow her to eat chicken and eggs and any protein diet. This is because if she eats the above food items, the baby will be too big in her stomach and during delivery she will find it difficult."

—*woman in Nigeria*

"She should be eating a lot, and not just anything but a balanced diet because it is from what the woman eats that the child will eat."

—*woman in Nigeria*

## **Question Areas About Practices During Birth and the Immediate Postpartum Period:**

### ***Prenatal***

- How do women recognize when labor has begun? What do they do?
- Do women/families make plans for childbirth attendance prior to initiation of labor? When? Why? Where?

### ***Delivery***

- Where do women prefer to give birth? Why?
- What are women's preferences for home birth versus hospital birth? Why? What terms do women use to describe a desirable/optimal birth experience?
- How amenable to change are women's choices of birth location? Under what conditions?
- Do women/families recognize women at risk for problem birth and seek a hospital or attended delivery? Why, why not?

- What are women's perceived need for/benefits of trained birth attendants?
- What type of birth attendant do women prefer? Why? How is the birth attendant selected? By what criteria? By whom?
- Do pregnant women have routine contact with the birth attendant during the prenatal period? When? Why?
- For home births, do families prefer traditional attendants to formally trained (such as government midwife) home attendants? Why?
- What are the routine practices of traditional birth attendants or family help regarding:
  - hygienic birth techniques, management of normal births?*
  - use of safe delivery kit, conditions of use?*
  - intrapartum abdominal massage or manipulation?*
  - use of drugs (especially oxytocins, natural or medical formulation)*
  - intrapartum and postpartum?*
  - cord cutting, dressing and aftercare?*
  - management of the placenta?*
- Are these traditional practices helpful, harmful?
- Do TBAs initiate these practices? Do women/families request them? Condone them? How amenable might they be to change?
- Do TBAs generally refer "high risk" clients (or clients with health problems) to the formal health system? When and to whom?
- What special facilities (such as community birthing huts or waiting homes) exist? How are these regarded by women, TBAs, the community and midwives?

### ***Postpartum/Neonatal***

- If most births take place at home, what postpartum problems are recognized by women/families/home birth attendants as requiring additional care/referral outside of the home?
  - For each recognized problem, what triggers a health-seeking response? What is that response?*
- What is the local definition/perception of the postpartum period? What changes in maternal nutritional/activity patterns take place? Why? Are they helpful/harmful?
- Does the concept of postpartum confinement or confinement hut exist? To what degree is it adhered to?

- What are the routine newborn-care practices of birth attendants regarding care of eyes, airway, warming, cord care, initiation of breastfeeding? Why? Are actions helpful/harmful?
- Do mothers/families/birth attendants recognize common neonatal problems/danger signs? Which ones (neonatal sepsis, neonatal tetanus, asphyxia/ hypoxia, low birth weight, hypothermia, acute respiratory infection)?
- How do they recognize these conditions?
  - What terms do they use to describe them?*
  - Do they feel that they are serious problems?*
  - What health-seeking behavior do they take? When? Why?*
  - What triggers action to seek care outside of the household/traditional practitioner? Why? When?*
- What maternal postpartum care practices are routinely tried out by birth attendants? Why, when? Helpful/harmful?
- What maternal postpartum problems/conditions are recognized by mothers/families/birth attendants? What actions are taken? When? Why?
- Do mothers/families comply with referral upward for medical care of postpartum problems? Why, Why not?
- What are women's/families'/birth attendants' perceptions of ideal size for their baby at birth and why?
  - What terms do they use to describe it?*
  - What significance do women give to their baby's birth weight and why? Is it a concept they understand and that they think about during pregnancy?*
  - Do they relate birthweight to the health of a newborn?*
  - If a "small" baby is desired, are there any reasons/terms which might be used to acceptably promote the advantages of giving birth to a higher (normal) birthweight baby?*

### **Breastfeeding Initiation**

- How soon after birth do women initiate breastfeeding? Why?
- What are women's attitudes and practices regarding feeding colostrum? How strongly are these attitudes held?
- What are TBAs', husbands', mothers-in-laws' attitudes toward feeding colostrum? Why? Who has the most influence on the mother in this regard?

- Do mothers give any other liquid or food to the child other than breast milk? When (e.g., first, second hour; first, second day)? What? Why? How? Any concern for hygiene? How strongly held is this practice?
- What are TBAs', husbands', mothers-in-laws' attitudes toward giving these other substances? Why? Who has the most influence on the mother in this regard?
- How do mothers feel about breastfeeding, e.g., do virtually all women have the same practices or do they consider it something they may decide to do/not do, do in a certain manner or pattern?
- How many times a day do mothers nurse?
  - For how long?*
  - Do they use both breasts? (answers should be based on observation rather than reporting)*
- What initiation problems are common? What do they do? Who do they see for advice?
- What are their perceptions about breast milk production and contact suckling?

## Answers:

Doctors are against nurse/midwives being trained and allowed to perform lifesaving skills like I.V. infusions, giving antibiotics, performing manual removal of placenta, vacuum extraction, etc....At the time of the study, there was no single obstetrician/gynecologist in the employment of the...state government, while most general hospitals were reputed to have less than three medical officers.

—Nigeria

Gopal Daktar's reputation has spread....He treats many conditions but his specialty is difficult deliveries. We met him again, assisting a young woman expecting her first child. In this case, [she] had been in labor for twelve hours. For a first child, this may not be abnormal but the dai panicked and said she could do nothing more....Gopal Daktar was called and after asking the guardian: "Do you want the fruit or the tree?" he proceeded to dismember the baby inside the womb with his instruments. It was bloody and messy said an informant, and the mother had high fever for a few days afterwards. Gopal Daktar is prepared for this, however, and has efficient medicines to deal with fever. As far as we know, he has not been seen responsible for any maternal death, but we were only there for a short period of time. Villagers are aware that his practice borders on illegality, but families which have been helped by him generally speak positively of his intervention.

—Bangladesh

"Hospital baby is much safer than at home because some time the mother can fall into difficulty and trying to find something to rush her to hospital could cost the baby's life."

—woman in Jamaica

"Obstacles or complications that a woman may have when she is pregnant at times is that the child may not be turning around. We then take such a woman to whoever is helping to treat her....the doctors could be of help, our fathers could do it and some religious sect can do it with lots of prayer."

—*woman in Nigeria*

"It [malpresentation] is not a frequent problem but it is serious; once it occurs, it presents complications, the baby cannot be born; the mother and the baby will die for sure. The family is then abandoned. We need a lot of money for treatment. Due to lack of economic resources, we must stay and die here."

—*woman in Inquisivi, Bolivia*

"How will one know when there is too much blood? But if it is in the hospital, once the nurse sees her, they will know if the blood is too much or not and they will know what to do to stop the excessive flow."

—*woman in Nigeria*

"You need someone to comfort you; instead they [hospital staff] are adding fury to the fire... is like you have a gun shot and they take you to hospital and you get another shot."

—*woman in Jamaica*

The problems of [the district] hospital are common to many such institutions and are well known in Bangladesh. There is no blood bank, and no staff and no equipment to perform Caesarean sections or other emergency obstetric procedures. As the doctors are all men, village women, especially Muslims, are reluctant to be seen by them. Doctors attribute these attitudes to women's ignorance and lack of education. In their understanding, it is not the medical profession which should adapt to village society but village women who should be 'educated', 'trained' or 'enlightened' to value the services they provide. To be posted [here] is regarded by most doctors as punishment. These professional men, most of whom come from larger cities, feel socially very cut off and isolated...Even if they had an interest in obstetrics (which is not obvious), they would have very little opportunity to develop their skills with so few patients. There is no antenatal clinic at the hospital and usually no contact is established with pregnant women during pregnancy. Women are brought to the hospital only when there is a severe complication.

—*Bangladesh*

"You are more comfortable at home because sometimes it is plenty deliveries at the hospital and at home Nurse spend more time helping you."

—*woman in Jamaica*

"I gave birth at home, in order to be calm, and because I wanted to be near my parents. They are already experienced...I was washing my clothes and felt a pain at my waist, as though I needed to defecate. My husband said maybe I was ready to give birth, but I told him no, because I didn't know...my parents went to find the paraji [TBA] but she was out. Soon after, the baby was born and my grandmother helped me deliver... the paraji still hadn't arrived. A neighbor helped bring out the placenta. The paraji came half an hour later, cut the cord, bathed the baby, and massaged me..."

—*woman in Tanjungsari, Indonesia*

The placenta is the baby's source of life. This is why the cord is usually not cut before the placenta is ejected. Once ejected, if the baby shows no sign of life, the placenta will be manipulated, heated up, trampled on, the cord will be squeezed and massaged to bring a flow of life from the placenta to the baby.

—*Bangladesh*

"The first flow of breast milk is usually yellow. It cannot be given to the baby because it causes yellow fever."

—*woman in Nigeria*

The dai (TBA) is taught to protect the mother from possible contamination, but what is important from an indigenous point of view is to contain the pollution. In this perspective, it is upon the completion of her work that the dai should wash carefully. There are here two epistemological universes with conflicting categories and meanings regarding cleanliness and dirt, purity and pollution. Four days' TBA training evidently do not suffice to change such deeply ingrained perceptions and beliefs.

—*Bangladesh*

"In my case, [labor] was three to four days. I usually take Arabic writing from the Arabic teacher to quicken it."

—*woman in Nigeria*

"When we are pregnant and we want to go to the hospital, other members of the family will start abusing us that we are not ashamed of ourself in taking our pregnancy to the hospital, while our elders did not."

—*woman in Nigeria*

"You take a pregnant woman to Westlands at night, and they tell you the case is complicated so you must go to Pumwani [maternity hospital]. Reaching Pumwani, you wake up the staff who are sleeping and they ask for your [delivery] card. They see that Westlands is written, and they tell you to take her back there."

—*man in Kenya*

"We have no objection towards our wives delivering at either clinic or hospital concerning their health because we know that they are delivering in a place where we are sure of their successful delivery. But our feeling is the cost of hospital charges and transport. In addition to that, we Fulani people are lowered to the lowest level by the hospital staff simply because we are in a bush. For example, you take your wife to the hospitals, the hospital workers will first of all order you to stay under a tree or veranda. They will go away for a long time and later come back to tell you that the doctor is busy and that you cannot simply see him—unless if you do something; that is, you give money to him so that he can connect you with the doctor."

—*man in Nigeria*

"At home, [delivery] is private, you don't pay anything, it's affordable...more comfortable, no one looks at us, and also our husbands are with us—they say in the hospital they put us on a cold table, and we're naked and they laugh when we complain about any pain."

—*woman in Cochabamba, Bolivia*

## Question Areas About Family Planning:

- To what extent do women and men want to have control over when they have their next baby and how many children they have? Why?
- When, after delivery (e.g., six hours; six days; six weeks; six months), do women think about using family planning to delay or prevent their next pregnancy?
- When, after delivery (e.g., six hours; six days; six weeks; six months), are women approached by health providers to consider family planning?
- What are people's desired birth intervals and total number of children? Why?
- What, if any, family planning methods are people using now? Why? How satisfied are they? Which method or methods is/are most acceptable? Why?
- Who influences/is involved in discussion concerning family planning? Do husbands and wives talk about family planning? What do they talk about?
- What are the major cultural values that inhibit higher acceptance of family planning?

## Answers:

"Some men say they came to this world to obey God's law: to have as many children as He gives us, no matter how many, 18 or 20, and women must obey as well."

—*woman in Inquisivi, Bolivia*

Reshom Banu is eight months pregnant and is still breastfeeding her three-year-old child. She made only one antenatal visit and the record shows that at six months pregnancy, she weighed 35 kilograms...Her husband does not care about her well-being. He does not inquire whether she has enough to eat; he does not ask what she thinks of yet another pregnancy. Reshom looks overwhelmed. She has no energy. She has had six pregnancies in 12 years....Her husband does not want to discuss family planning. He is the disciple of a [holy man] who forbids what is seen as interference with Allah's plan. The [health provider] classifies this family as amongst those who "do not listen," and seems to have given up trying to influence them.

—*Bangladesh*

"No, no, we don't plan our family. This is prohibited."

—*man in Nigeria*

"And the most important of all is that whatever plan you make as to the number of children you want, God has already made the provision for you."

—*woman in Nigeria*

"If we have those types of women who deliver year after year, we look for traditional medicine, using traditional herbalists, religious mallams, etc., to see that she resumes normal duty. And if that does not solve the problem, we usually cut off sexual relations for a year from the date of their previous delivery. This decision is made with the knowledge of the wife because she knows that such delivery is considered bad among the community and she will welcome it [the decision]."

—man in Nigeria

### **Question Areas About Feelings of Maternal Control Over the Situation (*self-esteem, aspirations for self and baby*)**

- What is women's self-image?
- What do women feel about control over their lives and health, especially reproductive health?

*Do women feel that they themselves can take action to improve their health and the health of their newborns/families? Why, why not?*

*Who else do women feel control their actions/activities in these areas, especially health-seeking behavior during pregnancy and postpartum? Why? How?*

*What are women's aspirations for themselves overall and during pregnancy and birth specifically? For the outcome of their pregnancy and the health of their newborn?*

- What are women's life aspirations for their children? How much control do they feel they have over their children's well-being and happiness?
- Do women feel they can talk openly about problems and their solutions with other family members?
- What do men, mothers-in-law think about a wife's/daughter-in-law's status?

### **Answers:**

Not only is the community led exclusively by men, but in the family, it is the man who most often makes all financial decisions. Most [field staff] have witnessed cases of husbands deciding that it would cost too much to send a woman with complications during her labor or pregnancy to the hospital.

—Inquisivi, Bolivia

In Nasirnagar, it appears that some degree of conformity to the norms of purdah procures dignity and prestige which may be important to the poor and which they certainly cannot achieve through their consumption style. Unfortunately, the greater seclusion of pregnant [women] and new mothers limits their ability to tap certain resources which could improve their nutrition. Those limitations make them highly dependent on a husband provider.

—Bangladesh

"I don't normally care about such things [care during pregnancy]. I just stay as I am normally: even if I am sick, my husband will hardly know it, except when it is beyond my control."

—*woman in Nigeria*

Eating order and differential entitlement to food in Safia's family are expressions of hierarchy, authority and power in a context of poverty. A woman identified as being at-risk because she is malnourished can be beaten for eating too much, i.e., more than her allocated share. That such behavior occurs must be recognized.

—*Bangladesh*

"We don't have any belief which is against attending maternity or hospital in this village. But our religion prohibits a married woman to expose herself to the public, except if the circumstances warrant it like health [sickness], greeting parents, performing condolence."

—*man in Nigeria*

"I as a person, I decide on where she should go because I look at it that if there is any problem, she is not the one that has the problem per se, I am the one that has the problem, that's why I make the decision about where she should go."

—*man in Nigeria*

As one might expect, the most frequent reason not to come is that a visit to an antenatal clinic would entail an infringement of purdah. Purdah, for some, is above all a religious matter and may be associated with a feeling that Muslims should take nothing from what is regarded as a "Christian" organization. But, for the rich especially, it is usually not so much a matter of religion as one of social prestige. Women of "good," (i.e., elite) families must stay apart and not mix with the common people.

—*Bangladesh*

The post-harvest period is one of intense activity for women....Those at the end of a pregnancy and those with small babies have conflicting obligations which are difficult to reconcile. Pregnant women identified at risk are unlikely to leave their work to go to a health center...unless they are seriously ill and totally incapable of functioning. One must appreciate their dilemma. Rice is their livelihood. It is health and wealth for the entire family.

—*Bangladesh*

"I don't want care from anybody, I just seek help from God."

—*woman in Nigeria*

## Question Areas About Communication

### *Influentials*

- Whom do women most commonly consult and respect regarding reproductive health and pregnancy-related concerns and problems?

*What advice do they get from these sources?*

*What level of awareness do these sources have about maternal and neonatal health problems?*

- Who else in the family or community may hold perceptions that influence maternal health or health-seeking behavior and which might require change?

*How do these people influence the mother? In what way might they influence the woman to take or not to take the desired action?*

- Who are the formal and informal authority figures for mothers? Who should be the authority to deliver or support mass media messages? From what institution (if any)?

- Which *named* personalities (i.e., respected figures) might be used to “sponsor” the effort? And in what way?

- What formal organizations or informal groups do women belong to? Where do they gather? What benefits do women perceive they receive as a member of such groups?

- What, when and how frequent are women's interactions with TBAs and other health workers, during pregnancy and postpartum especially? Would these health workers be a credible source of information?

### *Mass Media*

- What is the time/place/frequency of current receipt of messages via mass media and interpersonal (face-to-face) communication, and the frequency of contact with any potential communication contact point (meetings, visits to markets, town, etc.).

*What (if any) health messages do women now receive? How often?*

*From where? What do they think of them?*

- What is the extent of radio/TV ownership and conditions of listenership (time, station, favorite programs and format)?

*Probe the value of messages heard by husbands/influentials and if passed to wives. If so, how, when? If not, why not?*

*What is their exposure and confidence in health (especially pregnancy-related) information from mass media (radio, TV, print media)?*

- What is the potential value (acceptability, credibility) of “word-of-mouth” channels of communication?

## **Language**

- What is the precise language, verbatim, used to describe the common symptoms, illnesses and danger signs of pregnancy, birth, and postpartum periods?
- Make a compendium of local maternal and neonatal health and nutrition words and phrases for use in health communication messages.

## **Answers:**

“When they [husbands] look after us we feel important and we can see whether they love us or not.”

—*woman in Inquisivi, Bolivia*

About half the respondents said that they recalled hearing health information on TV or radio. However, health messages on topics such as family planning or immunization and advertisements for commercial headache or flu remedies such as “Bodrex” or “Antalgin” are equally regarded as “health advice.”

—*Tanjungsari, Indonesia*

In traditional extended families, wives who come to the antenatal clinics or are interviewed at home meet outsiders in the presence of the mother-in-law. Therefore, it is impossible for young wives to speak openly about their health problems if this would imply any possible incrimination of their in-laws.

—*Bangladesh*

“The radio is in the house, but I have never cared to listen to the program attentively. I have a lot to do here.”

—*woman in Nigeria*

“What I believe is that, it is the elders, our husband's mother, that usually tell us these things are taboo and once they say so, we believe.”

—*woman in Nigeria*

## ***Bibliography: Formative Research***

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1. For copies of the following formative research reports, please address inquiries to:

**John Snow, Inc.**  
1616 N. Fort Myer Dr.  
Arlington, Virginia, 22209 USA  
Attn: MotherCare Publications

(Please request the general MotherCare bibliography for a complete listing of *all* special reports, working papers and trip reports)

2. For further information on formative research, please contact:

**The Manoff Group**  
2001 S. St., NW, #510  
Washington, DC 20009  
(Telephone: 202-265-7469; Fax: 202-745-1961)  
Attn: Marcia Griffiths, President

## ***Reports***

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Working Paper 2  
November, 1990  
Mona Moore

*Communicating Safe Motherhood: Using Communication to Improve Maternal Health in the Developing World*

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July, 1991  
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Carolyn Fessler-Radelet  
Leslie Carlin

**Jamaica:**

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August 1993  
Donna K. Pido

**Nigeria:**

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August 1993  
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*Nigeria Maternal Health Project Qualitative Research*

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Public Opinion Polls, Ltd.; Lagos, Nigeria

# *Part III*

## *Country Project Profiles*

### *Introduction*

MotherCare supported over 13 projects in ten countries. Several projects conducted formative research and designed, pretested and implemented health communication strategies, messages and media materials with the help of MotherCare technical assistance. Seven of these projects' health communication components were selected to be profiled in this document: Bangladesh, Bolivia (Cochabamba), Indonesia (Indramayu and Tanjungsari), Kenya, Nigeria and the Philippines.

The projects not profiled either did not have a health communication component (Uganda and Ecuador) or developed or conducted the health communication process in such a project-specific way as to merit a separate unabridged description (Guatemala and Inquisivi, Bolivia). These projects' efforts are described in their final reports, working papers and special documents produced by MotherCare.

Those projects which are profiled here are also more fully described in final reports, working papers, trip reports and articles; a listing of these reports and documents is available from MotherCare. Documents relating to the health communication component of these projects are listed under each profile's bibliography segment.

### *Profiles of Health Communication Activities*

Each health communication profile has three major segments:

**Project Narrative:** Highlights of the research, messages, activities and findings specific to the health communication component are described. The narrative has several parts:

**Background:** This brief description sheds some light on the maternal health status and problems of the country or area where the project was implemented.

**Program:** This description puts the health communication component into the context of the larger project being implemented, as most projects also included clinical training, service delivery upgrading and research components.

**Formative Research:** This description highlights the research findings vital in shaping the health communication strategy. Details of the actual qualitative research conducted, including research plans, question guides, implementation strategies and results, can be found in the working papers and articles listed in the bibliography segment of each profile.

Strategy Formulation and Development: Initial orientation workshops, audience identification, message development and the media strategies resulting from such efforts are described in this section.

Implementation and Monitoring: A brief description of the media, messages and materials, is given, as well as any initial feedback from intended audiences on coverage, message retention and behavior change.

Findings and Future Directions: Major qualitative and quantitative monitoring and evaluation results that address the impact of the health communication component on knowledge, attitudes and behavior of intended audiences are described here. The projects' recommendations for redesigning aspects of the specific component as well as lessons learned are given.

**Samples of Health Communication Materials**: This part has photographs of sample materials developed for each health communication component. Each sample is briefly described with the principal message it conveys, and for whom it is meant for or to be used by.

**Bibliography**: This part contains three sets of information:

- the profiled project's contact name and address in-country;
- contact names and addresses in the U.S. where more information and documents can be obtained;
- a list of all trip reports, working papers (including research reports), final reports and articles pertinent to the design, development, implementation and evaluation of the health communication component of the profiled project.

# *Bangladesh*

## *Community Development Program*

### *Background*

Between 1987 and 1990, under-five mortality rates in Brahmanbaria district, Bangladesh decreased from 170 to 120—a decrease due, at least in part, to Save the Children's child survival interventions in the area. But extremely high rates of maternal and perinatal mortality persisted, warranting a new set of interventions focused on improved maternal care during pregnancy, delivery and the puerperium. The maternal mortality ratio for Bangladesh is approximately 600 maternal deaths per 100,000 live births. The Save the Children Bangladesh Field Office chose to implement a maternal health project with the above objectives in 16 villages in Nasirnagar Upazila, where socioeconomic and health indices are lower than in the district's other areas. Flooded for six months a year, Nasirnagar is geographically remote and culturally conservative.

### *The Program*

Save the Children (USA) Bangladesh Office (SCF) has combined maternal health interventions with ongoing child survival activities in the project area. SCF's health activities were integrated as much as possible into its economic development programs, in this case, women's savings groups. Training and placement of midwives at the community level formed the core of SCF's maternal health clinical intervention. The project had two phases: the first phase determined the major medical, cultural, social and economic causes of perinatal mortality; the second developed and implemented interventions to address those causes. Based on available anthropological and survey research, Save the Children, with support from MotherCare and a local, private health communication agency, undertook to develop, implement and monitor the use of health communication materials to affect health and nutritional behavior change among women and their influentials, mainly their husbands and mothers-in-law.

### **Formative Research**

In order to derive strategies and messages for a health communication campaign, data were obtained from several pieces of research conducted to determine causes of perinatal death and obstacles to appropriate care. Two quantitative studies—a case study of neonatal deaths and stillbirths and a Mid-Upper Arm Circumference (MUAC) survey—were conducted to obtain information about the general consequences of health behaviors among pregnant women. Simultaneously, an anthropological study, conducted over a six-month period in the project area, revealed why those health behaviors were practiced.

In general, the studies showed that malnutrition appeared to determine the outcome of pregnancy and birth for most pregnant women and neonates. Over 63 percent of all 15 to 45-year-old women in the project area were defined by the MUAC study as malnourished.

The anthropological research yielded a wealth of information about the social, cultural, economic and health context within which pregnant women try to carry to term, deliver and care for the newborn:

- Almost half the children conceived die.
- Pregnancy is considered a “normal,” not a “special,” condition of womanhood. Women’s eating habits, workload patterns and health care-seeking behaviors do not significantly change if they become pregnant.
- Husbands and mothers-in-law have a strong influence but play a passive role in caring for the health of the woman.

(NOTE: a baseline knowledge, attitude, practice survey conducted with pregnant women, their husbands and their mothers-in-law one year later confirms the influence of family members over a woman’s decision-making: 66 percent of husbands thought that routine prenatal care was important; 92 percent of their wives sought prenatal care. In cases where husbands felt prenatal care was not important, 53 percent of their wives sought prenatal care.)

- Poverty, religion (Islam and Hinduism) and the economic and social status of women within the household and within the community are major barriers to seeking health care.
- Training of traditional birth attendants (TBAs) has improved TBAs’ involvement with the Save the Children health care system.
- Emergency obstetrical care at the district hospitals is literally out of reach of villagers and is viewed with disdain by the community as a result of the hospital staff’s unfamiliarity with the community and the perceived quality of care the staff render.
- Intensive and extensive interpersonal communication exists between Save the Children village development workers and villagers, but their value is waning in terms of new and creative messages and motivational techniques.

The research also showed powerful evidence of the need for improved availability and accessibility of emergency obstetrical services and increased community awareness of when to seek those services.

## **Strategy Formulation and Development**

Subsequent to the research activities, a week-long orientation workshop was conducted with Save the Children’s program staff and program representatives from other government and non-government agencies working in maternal health to accomplish the following objectives:

- review the results of the quantitative and qualitative research and identify health communication, management and supervision, policy and training interventions to address maternal health issues identified by the research;
- elicit research results and experiences from government and non-governmental projects in maternal health to reinforce or reformulate proposed interventions; and
- review and verify research results and proposed interventions with project field staff and reshape them accordingly.

Based on the research results, experiences in Bangladesh and proposed interventions, health promotional practices were identified, refined and categorized in order to develop a sequence of 24 specific health activities a pregnant woman would take part in (or that her family/community, health care provider, or a combination thereof would take part in) chronologically from recognition of pregnancy through delivery to care for the newborn. They are:

#### **Antepartum**

1. Identify pregnant women and encourage them to attend prenatal classes and clinics for pregnancy monitoring, including check-ups, history-taking and weight monitoring;
2. Schedule tetanus toxoid shots for pregnant women;
3. Pregnant women receive and comply in taking iron folate tablets;
4. Pregnant women are given messages to increase quantity and quality of nutritious food consumed; supporting groups, such as husbands, mothers-in-law and the community at large, are given similar messages to enable pregnant women to follow messages;
5. Preparation for safer, cleaner birth and postpartum/neonatal care;
6. Recognition of minor and major ailments and danger signs and proper treatment and referral;
7. Request a Save the Children-trained TBA to attend the birth.

#### **Intrapartum (labor through placenta delivery)**

8. Do not withhold liquids from a woman in labor;
9. Use the Save the Children safer birth kit and techniques;
10. Recognize, treat and refer delivery complications;
11. Provide baby care before placenta is delivered by keeping baby warm and clean;
12. Provide immediate and exclusive breastfeeding;
13. Identify and refer for low birth weight and prematurity.

#### **Postpartum (0-42 days)**

14. Promote nutritious food for the mother;
15. Promote exclusive breastfeeding for five months (include maternal benefits, self-control issues and complications);
16. Identify and treat puerperal sepsis;
17. Promote consumption of iron folate tablets as a food supplement;
18. Provide vitamin A capsules for mother no later than two weeks after birth;
19. Provide family planning information to woman and husband no later than six weeks after delivery.

#### **Neonatal (0-28 days)**

20. Immediate and exclusive breastfeeding (for health of newborn);
21. Recognition and treatment/referral of ARI;
22. Proper cord care to prevent infection and tetanus;
23. Recognition, treatment and referral of neonatal illnesses;
24. Recognition and referral regarding infant/child developmental milestones.

This list formed the basis for developing health communication messages.

All communication activities needed to use existing and proven channels of communication (strictly interpersonal and print) to reinforce self-care by women and their families, build on Save the Children's program strengths of outreach, and strengthen linkages with obstetrical emergency care.

Therefore, community-based midwives were introduced to address some of the major complications. TBAs were trained not only in safer, cleaner delivery techniques and the recognition of complications but also to accompany their clients to prenatal care clinics and discuss their cases with the midwives. Motivational materials were designed as part of the community development approach of SCF and addressed the need for pregnant women, their family members, TBAs and women's savings groups to be more proactive in complying with routine prenatal care and recognizing danger signs during pregnancy.

## Implementation and Monitoring

A combination of frequent and consistent technical assistance by the Manoff Group and the hired services of a local communication agency, Associates for Communication Options (ACO), assisted Save the Children staff in designing, pretesting and producing messages and illustrations and the format in which they were to appear. Pretesting required testing of the utility of the messages and material with village development workers, as well as evaluating appropriateness and appeal with villagers.

The messages and materials were designed to stimulate interaction between a pregnant woman, her husband and her mother-in-law. A suggested practice was negotiated between the pregnant woman, her husband and her mother-in-law and the village development worker. Messages to pregnant women, their husbands and their mothers-in-law were presented in a fashion that elicited a response by each to the question, "Will you do/support this practice? How?" The print materials were introduced to the village development workers through a series of workshops orienting them to the project, the use of the materials and innovative adult non-formal education techniques.

The health communication materials as well as the strategies for introducing community midwives and upgraded TBA training were launched with villages through several public fora that brought guest medical speakers from Dhaka. These public events not only raised awareness of maternal health issues but also brought legitimacy to the interventions from traditional and religious leaders and a new credibility and esteem to the Save the Children village development workers, who were presented in a new light with new materials.

At the household level, health communication messages were developed to reach husbands and mothers-in-law as well as to the women themselves. These messages emphasize the importance of such issues as:

- adequate maternal nutrition during pregnancy and lactation;
- prenatal care and iron intake;
- seeking care for problems during pregnancy;
- using a trained TBA and seeking help early in case of problems;
- exclusive breastfeeding for the first five months postpartum; and
- use of contraception.

Save the Children's village development workers deliver these messages with the aid of illustrated counseling booklets; female workers communicate with mothers and mothers-in-law and male workers with husbands. The household keeps the book, as well as four reminder posters reinforcing messages on taking iron tablets, eating more frequently, safer, cleaner delivery and postpartum/neonatal care. These posters are given to pregnant women at appropriate times during the pregnancy.

Counseling by health workers is improved through their use of communication materials. Flipcharts, with illustrations and captions from the counseling booklets, are used during prenatal care sessions to reinforce messages to mothers. TBA action cards are designed to remind TBAs of steps needed for safer delivery and of danger signs which warrant referral; these cards are retained by TBAs. Once trained, TBAs are also provided with TBA kits, medications and supplies, and they receive refresher training every three months.

Recognition of conditions which require early referral is emphasized, as is seeking emergency care. In order to reduce financial obstacles that will continue to preclude follow-through on recommendations for referral to a hospital, SCF is now in the process of establishing emergency referral funds in its women's savings groups.

Monitoring is being done on a routine schedule through interviews with clients and health workers. A baseline knowledge, attitudes and practice household survey was conducted with pregnant women, their husbands and their mothers-in-law (or elder "sisters") a few months prior to the introduction of the health communication intervention.

## *Findings and Future Directions*

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The baseline survey is based on the messages contained in the print materials. The survey asks similar questions of the pregnant woman, her husband and her mother-in-law (e.g., "Do you think a pregnant woman should eat more, less or the same amount of food as she did before she was pregnant?") but also asks each interviewee to comment on whether the other family member agrees or disagrees with the answer. Some of the findings, which will be compared to results of the post-intervention evaluation survey (to be conducted late 1993), are as follows:

- 75 percent of mothers had at least one prenatal care check-up during their last pregnancy; only 12 percent started prenatal care in their first trimester.
- 29 percent of mothers ate more than usual during their last pregnancy; 87 percent knew they should have eaten more. 66 percent of husbands said that women should eat more during pregnancy.
- 43 percent of women with bleeding sought treatment; 56 percent of women with facial edema sought treatment.
- Although 77 percent of mothers started breastfeeding on day one after delivery, 83 percent gave additional liquids or foods as well. 73 percent were aware that only breast milk was needed in the first five months of life, but 40 percent felt their breast milk was not sufficient.
- 30 percent of mothers, 35 percent of husbands and 42 percent of mothers-in-law identified two or more years as the optimal interval to "rest" between pregnancies.

Several lessons have been learned to improve communication activities and strengthen service provision and utilization:

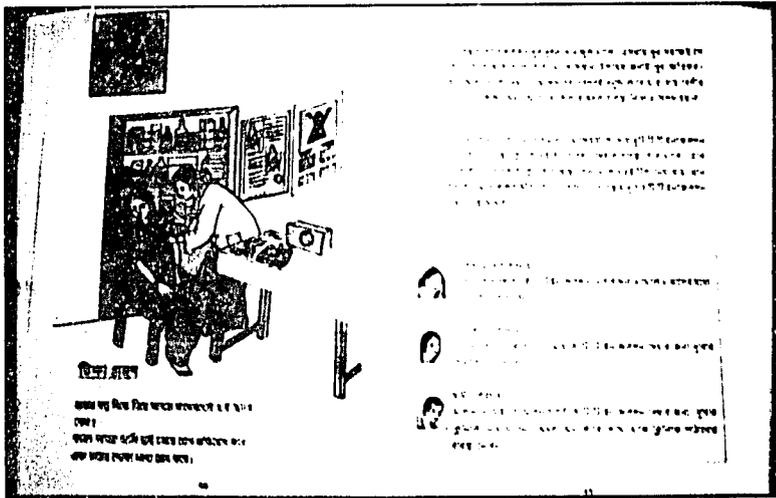
- Effects of health communication activities can be maximized by targeting influential family members as well as pregnant women.
- Exposure to health communications alone may not be enough to close the gap between knowledge and practice. Poverty and lack of proper food may limit the impact of health communication interventions on some problems.
- To maximize gains in maternal and neonatal health care, behaviors of health care workers as well as families must be modified. Results from the case study indicated a need for improved case management skills among all levels of health care workers. Also, given the short time frame of the project, possibly more has been accomplished by improving case management skills than focusing upon behaviors which are greatly influenced by economic factors and cultural beliefs.
- Influential community decision-makers (e.g., political and religious leaders) must be convinced about the importance of improving women's health before they will support behavior changes (e.g., leaving the home for prenatal care) that challenge the traditional order. It is advantageous to demonstrate to such leaders that all women, regardless of their socioeconomic status, are vulnerable to complications during pregnancy and delivery and that health benefits from improved maternal health will accrue to children as well as women.

Save the Children has introduced the strategies, processes, print materials and research results to other NGO and government agencies concerned with promoting maternal health. SCF's experience in Nasirnagar is also being adapted for implementation in other districts in which SCF is working in Bangladesh and is being reviewed at Save the Children's US headquarters for replication in other countries.

# Bangladesh Health Communication Materials



A. Motivational Booklet for Use by Social Workers With a Pregnant Woman, Her Husband, and Her Mother-in-Law on Prenatal, Intrapartum, Postpartum and Neonatal Care



B. Negotiating Healthy Behaviors With the Pregnant Woman, Her Husband, and Her Mother-in-Law (from motivational booklet)

B1. Attending prenatal care clinic



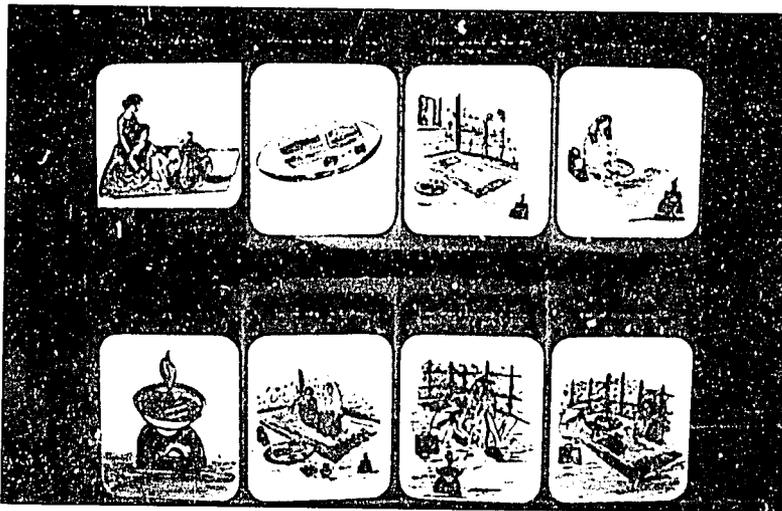
B2. Danger signs



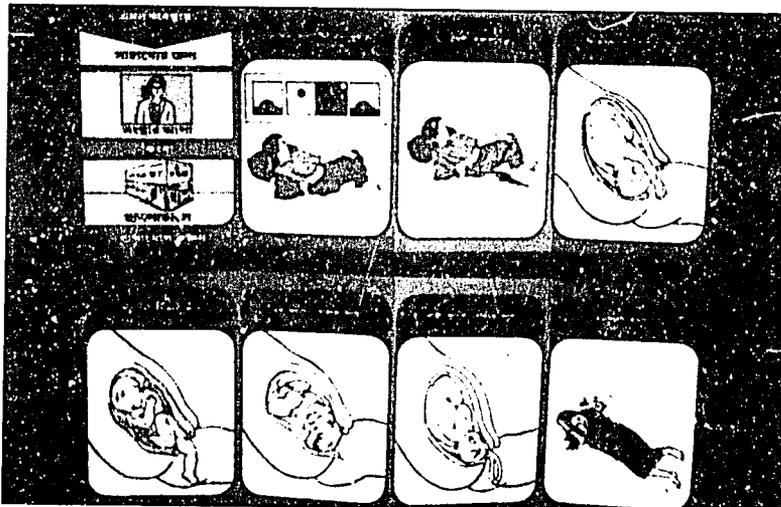




C4. Postpartum and neonatal care



D. Action Card for TBAs on Safer, Cleaner Delivery Techniques



## ***Bibliography: Bangladesh***

1. For further information and copies of the original materials produced under the health communication component of this project, please contact:

**Save the Children/USA (Bangladesh Office)**

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Contact: *Dr. Afzal Hussain, Principal Investigator, SCF/MotherCare Project*

2. For copies of the following reports, please address inquiries to:

**John Snow, Inc.**

1616 N. Fort Myer Dr.

Arlington, Virginia, 22209 USA

Attn: *MotherCare Publications*

(Please request the general MotherCare bibliography for a complete listing of all special reports, working papers and trip reports)

3. For further information on social marketing and health communications, please contact:

**The Manoff Group**

2001 S. St., NW, #510

Washington, DC 20009 USA

(Telephone: 202-265-7469; Fax: 202-745-1961)

Attn: *Marcia Griffiths, President*

## ***Special Reports***

MotherCare Final Report

Bangladesh Final Report

*Maternal Health in Rural Bangladesh: An Anthropological Study of Maternal Nutrition and Birth Practices in Nasirnagar, Bangladesh*

October 1991

Therese Blanchet

(Save the Children/USA and Ford Foundation study)

## ***Working Papers***

*Behavioral Determinants of Maternal Health Care Choices in Developing Countries*

Working Paper 2

November, 1990

Mona Moore

*Interventions to Improve Maternal and Neonatal Health and Nutrition*

Working Paper 4

December, 1990

Niki George

*Communicating Safe Motherhood: Using Communication to Improve Maternal Health in the Developing World*

Working Paper 14

November, 1991

Marcia Griffiths

Mona Moore

Michael Favin

**Trip Reports**

*MotherCare/Save the Children Bangladesh Project (a review of quantitative and qualitative formative research)*

October 18 – November 7, 1991

Katherine Kaye

*MotherCare/Save the Children Bangladesh Project: The Social Marketing/Information, Education, Communication Process and Progress*

October 16 – November 8, 1991

Kim Winnard

Richard Pollard

*MotherCare/Save the Children Bangladesh Project: Refinement of the IEC Implementation Plan*

February 1– 21, 1992

Richard Pollard

*MotherCare/Save the Children Bangladesh Project (pretesting of health communication materials)*

May 26 – June 14, 1992

Richard Pollard

*MotherCare/Save the Children (USA) Bangladesh Project (finalization of health communication materials)*

August 29 – September 3, 1992

Kim Winnard

# *Bolivia*

## *Cochabamba Reproductive Health Project*

### *Background*

Bolivia has the highest maternal mortality ratio in Latin America, an estimated 480/100,000 live births. Paradoxically, nationally there is one doctor for every 2000 people (similar to Costa Rica) and in urban areas, up to one doctor for every 410 people (similar to Sweden). Cochabamba is the third largest city in Bolivia. In this project covering Cochabamba poor urban and periurban areas, service delivery assessments have revealed that even though maternal health services are widely available, they are grossly underutilized because of poor quality of care (lack of equipment, ineffective use of referral system, poor client counseling) and the lack of information available to communities about why to use routine and emergency prenatal, delivery and postnatal health care services.

### *The Program*

Working with the local public health authority and several local non-governmental organizations (NGOs) offering health services in Cochabamba, MotherCare's program seeks to increase the public's demand for reproductive health services, improve the quality of those services, and, subsequently, contribute to an eventual decline in maternal and neonatal mortality. The project has four principal components: research, health communications, training, and service enhancement.

The health communication component was designed to address some general maternal health care needs:

- increasing awareness of policy makers and service providers about the prevalence of maternal mortality and morbidity and the client and provider behaviors that contribute to or prevent those conditions;
- increasing the recognition of danger signs and complications during pregnancy, delivery and the neonatal period by women and their families, as well as improving their response to such problems, i.e., seeking medical attention;
- increasing the utilization of routine prenatal, delivery and postnatal care; and
- increasing the number of home deliveries attended by a trained health care provider equipped with a "Safe/Clean Birth Kit" and techniques.

### **Formative Research**

A qualitative study of women's reproductive health knowledge, attitudes and practices was designed by expatriate consultants and a local private research agency, Center for Health Research, Consultation and Education (CIAES). CIAES carried out the study, receiving assistance in analysis from an expatriate anthropologist.

The objectives of the study were to describe and better understand the population's perceptions and behaviors in relation to the formal health care system. Over 230 women participated in focus group discussions, in-depth interviews and clinic exit interviews. Traditional birth attendants were also interviewed, and clinic-based observations of client-provider interaction were made.

The study focused on five stages in the reproductive cycle and three related topics:

- pregnancy
- labor and delivery of the infant
- delivery of the placenta
- the immediate postpartum period
- the newborn period
- breastfeeding
- family planning
- abortion

Findings were analyzed by reproductive stage and topic and as a whole to generate an ethnophysiological model, or an explanation of the way in which the women interviewed understand the physiology of the human body and reproduction. This analysis enabled the investigators to compare the women's (Quechua-Aymara) view of physiology with the biomedical model maintained by health workers in the formal health system. Following are some examples of key issues and the disparate perspectives of pregnant women and their formal health care providers:

<b>Issue</b>	<b>Quechua-Aymara System</b>	<b>Biomedical System</b>
<b>danger signs</b>	edema is a "positive" sign for a healthy delivery	edema of the face and hands needs to be addressed urgently
<b>room temperature</b>	warm environment	cold environment
<b>ventilation</b>	no air currents	ventilated rooms
<b>attendants</b>	husband, mother-in-law, TBA	doctors, nurses, interns
<b>clothing</b>	heavily clothed and wrapped	light, loose gown
<b>preparation</b>	none	enema, wash and shave vaginal area
<b>labor position</b>	vertical	horizontal
<b>delivery position</b>	kneeling	supine gynecological position
<b>care of placenta</b>	bury or burn in home area	throw in trash
<b>primary concerns</b>	modesty, privacy, well-being of women; adherence to protective customs	proper biomedical techniques; asepsis; well-being of infant; other patient needs.

Highlighting areas in which the two systems are in harmony, in ignorance of one another, and in conflict, findings then were used to develop intervention strategies to improve home practices, increase the appropriate use of formal health services, and to train health care providers to offer better quality services, i.e., more in keeping with women's needs and desires.

An important finding of this study is that "non-users" of Cochabamba's reproductive health services are not necessarily unaware of the existence of these services. In fact, they often have well-formed opinions about them and some level of appreciation for the expertise of health professionals. The factors that act as barriers to service utilization include the perceived mistreatment of women, institutional norms that conflict with women's modesty and ethnophysiology, the lack of information and orientation given to women during clinic visits, and the cost of services in both time and money.

## Strategy Formulation and Development

A three-day strategy development workshop was conducted to define specific health communication, training and service delivery activities based on the research findings. Working groups identified practices harmful to the health and survival of women and their newborns as well as factors which women said kept them from using available health services. Practices were prioritized from most to least harmful and from difficult to most easily changed. Activities were prioritized accordingly. Feasible behavioral objectives, basic messages, and motivational and inhibiting factors that would shape the acceptance or rejection of the new behaviors were developed. Over 30 participants from the various NGO and government agencies were involved in the exercise.

The resulting health communication plan proposed five implementation phases. Each phase would last three months. The first phase, "sensitization," was aimed at creating awareness among policy makers, health providers and others of the problems of maternal and neonatal health and the differences in perspectives on health care between the Quechua-Aymara peoples and the formal health system employing the biomedical model.

The subsequent four phases were defined by maternal health themes and sub-topics for women of reproductive age, their family members (especially husbands) and community leaders. The themes were on the importance and utilization of:

**prenatal care:** what it is, the importance of routine and timely emergency care; recognizing the signs of edema as a danger. This particular phase included six questions which a woman should ask her prenatal care service provider about her own health and that of her baby.

**safer/cleaner home delivery:** the use of sterile materials to cut and tie the umbilical cord; recognizing complications during and after delivery and what should be done; avoiding labor augmenters; safe delivery of the placenta.

**neonatal care:** immediate attention to the neonate before the placenta is delivered; immediate and exclusive breastfeeding, including the giving of colostrum; recognition of maternal and neonatal danger signs and what should be done.

**family planning:** advantages, methods.

These topics were to be staggered every four to five months in order to avoid overloading project team staff time and resources and to incorporate lessons learned into subsequent phases from previous phases. Each phase would employ similar media and materials:

- educational video and radio programs covering the general theme, with an accompanying TV and radio spot for each major sub-theme; and
- one flipchart per theme (with instructional guides) for health care workers and one educational leaflet for the family per sub-topic.

## Implementation and Monitoring

An inter-agency information, education and communication (IEC) committee with representatives of each participating agency was established in Cochabamba and health communication skills workshops were provided to all represented agencies to ensure an institutionalized capability to develop and implement the various phases. Expatriate technical assistance was provided, and two local health communication specialists were hired to implement and monitor the health communication strategy.

Training of service providers was given to upgrade clinical skills, as well as to adapt case management procedures to the needs of clients based on the formative research. Training in interpersonal communication skills and counseling and the use of the health communication materials developed by the project was also conducted as appropriate.

Due to the diversity of materials for each phase, the complexity of the messages and the health communication training process that was undertaken, only the sensitization, prenatal care and safer/cleaner delivery phases were implemented. Each phase took about six months to prepare, allowing for the participatory process of designing messages and media and intensive pretesting. However, the result was an IEC committee and staff that was able to mature in its technical acuity and its relationship with the project communities.

Monitoring was conducted by two local research agencies—CIAES and the University of Valle's Faculty of Communication. The monitoring exercise looked at coverage and the pervasiveness of the mass media and the messages being communicated.

## *Findings and Future Directions*

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Comparative data from baseline and final surveys yield the following results:

- Although no significant changes in total utilization of prenatal care services occurred in Cochabamba, increases in attendance from 17 percent to over 100 percent were seen at the clinics of four participating NGOs when compared to a similar six-month time period two years earlier.
- The percent of women who saw or heard a message about prenatal care rose from 42 percent to 71 percent; those who saw or heard a message about danger signs during pregnancy rose from 24 percent to 57 percent; women who knew any danger sign during pregnancy increased from 26 percent to 43 percent; and those who remembered edema as a danger sign rose from two percent to 64 percent (traditionally edema was thought to be a positive sign indicating an easy birth).

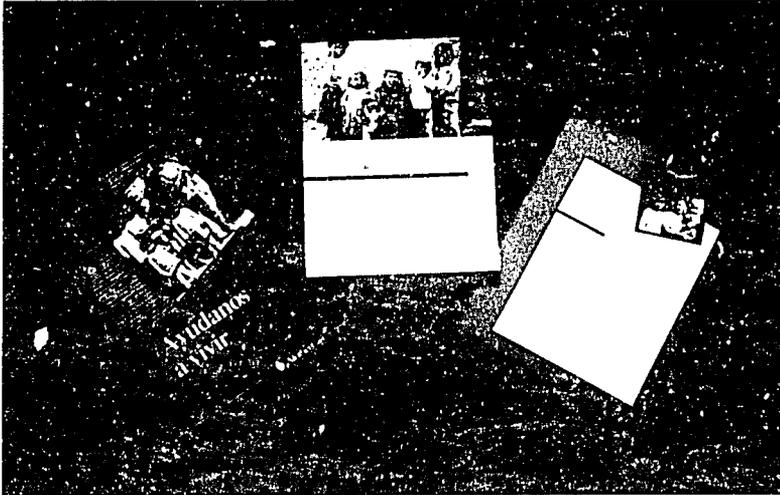
Key recommendations for future programming include the following lessons:

- The involvement of health workers in developing the philosophy and objectives of the project is essential. However, the challenge is to promote commitment on behalf of the health workers to change their attitudes and behavior towards the clients.

- NGOs were convinced to join the project because of the strategies that involved the utilization of formative research in the design of materials, the involvement of the community in the development of the materials, and a broader definition of reproductive health (prenatal, birthing and postpartum care, including the care of the neonate, and family planning).
- Certain "everyday" language used to promote awareness among clients was considered inappropriate by doctors for delivering medical and health information, demonstrating the need to further orient the health care staff to the needs of clients.
- Due to the implementation of the program in phases, health communication materials had an opportunity to improve in quality, messages could improve in accuracy and appropriateness, health workers became familiarized with materials at an acceptable pace and clients became used to and expectant of more information.

Because the existing Cochabamba project is an urban-based project promoting utilization of both private and public health services, there is an effort being made to expand the strategies and processes into other urban areas nationwide.

## Cochabamba, Bolivia Health Communication Materials



**A. Sensitization Campaign  
for Policy Makers**



**B. Prenatal Care  
Campaign—  
Health Educators'  
audio/video and print  
guides for using motiva-  
tional print material**





**C. Prenatal Flip Chart Messages**

**C1. What happens during a prenatal care visit**



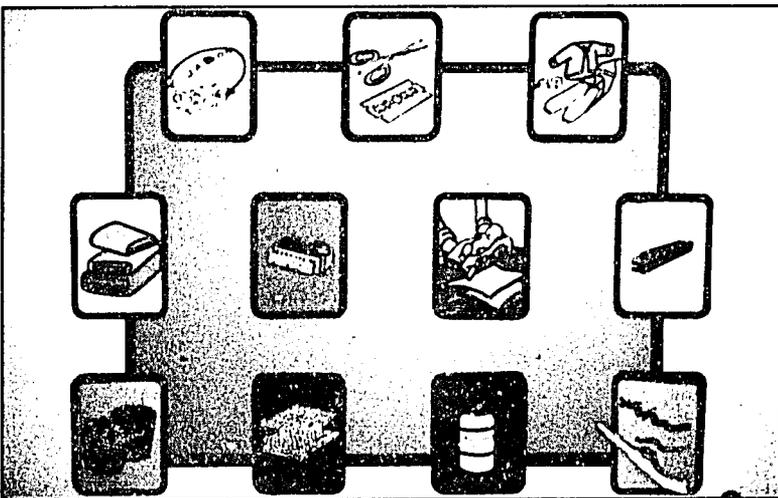
**C2. Danger signs**



**C3. Key messages to remember**

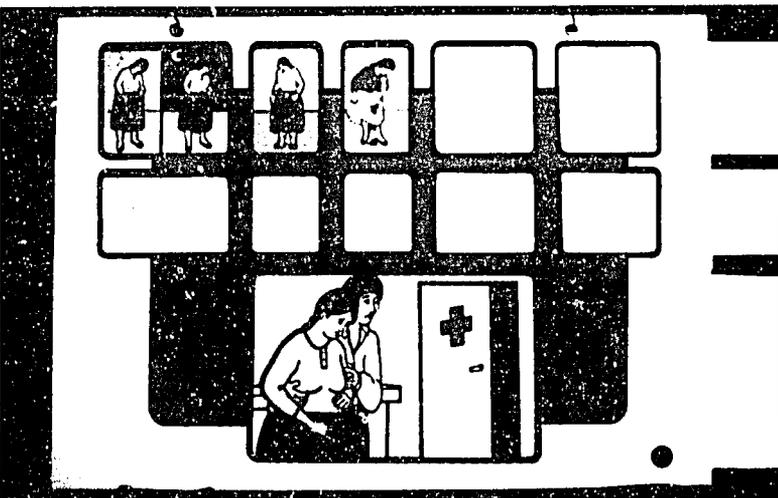


D. Safer and Cleaner Delivery Campaign—  
Health Educators' audio/video and print guides for using motivational print material

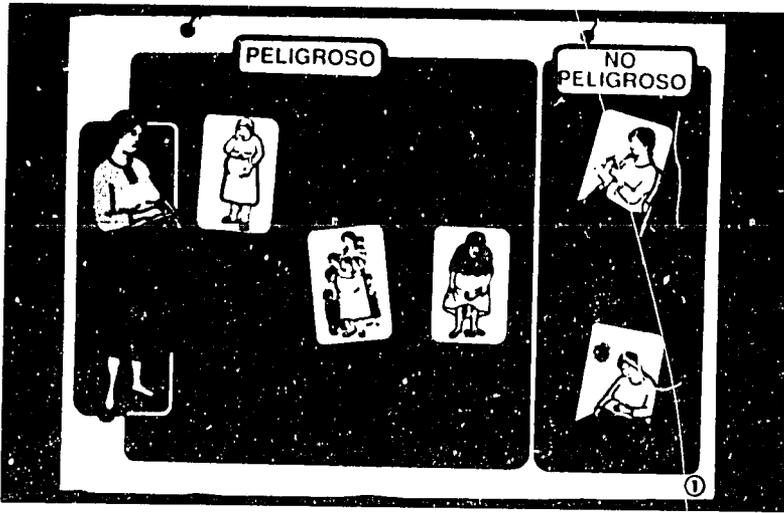


E. Safer and Cleaner Delivery: Participatory Flipchart Messages

E1. Safer, cleaner delivery methods



E2. Signs of complications



E3. Key messages to remember

## **Bibliography: Bolivia (Cochabamba)**

1. For copies of the following reports, please address inquiries to:

**John Snow, Inc.**  
1616 N. Fort Myer Dr.  
Arlington, Virginia, 22209 USA  
*Attn: MotherCare Publications*

(Please request the general MotherCare bibliography for a complete listing of all special reports, working papers and trip reports)

2. For further information on social marketing and health communications, please contact:

**The Manoff Group**  
2001 S. St., NW, #510  
Washington, DC 20009 USA  
(Telephone: 202-265-7469; Fax: 202-745-1961)  
*Attn: Marcia Griffiths, President*

### **Special Reports**

MotherCare Final Report  
Cochabamba Final Report

### **Working Papers**

#### *Behavioral Determinants of Maternal Health Care Choices in Developing Countries*

Working Paper 2  
November, 1990  
Mona Moore

#### *Interventions to Improve Maternal and Neonatal Health and Nutrition*

Working Paper 4  
December, 1990  
Niki George

#### *Qualitative Research on Knowledge, Attitudes, and Practices Related to Women's Reproductive Health: Cochabamba, Bolivia (available in English and Spanish)*

Working Paper 9  
July, 1991  
The Center for Health, Research, Consultation and Education (CIAES)

#### *Communicating Safe Motherhood: Using Communication to Improve Maternal Health in the Developing World*

Working Paper 14  
November, 1991  
Marcia Griffiths  
Mona Moore  
Michael Favin

## *Trip Reports*

*Assessment Report and Proposal for MotherCare Project in Cochabamba, Bolivia*

July 9 – 17, 1990  
Lisa Howard-Grabman  
Dr. Alfredo Guzman  
Dr. Pedro Rosso  
Patricia Taylor  
Melody Trott

*Cochabamba Bolivia Trip (health communication assessment)*

March 17– 20, 1991  
Mike Favin

*A Qualitative Assessment of Maternal and Neonatal Health Problems and Resources*

May 29 – June 15, 1991  
Susan Brems

*Strategy Development Workshops and Proposed Communication Plan*

August 26 – September 6, 1991  
Sonia Restrepo Estrada

*Transition From Qualitative Research to Program Development*

August 26 – September 5, 1991  
Susan Brems

*Design of the Baseline Study for Cochabamba, Bolivia Project*

September 14 – 27, 1991  
Nancy Sloan

*Strategy Design of IEC Component (in Spanish)*

November 18 – December 6, 1991  
Sonia Restrepo-Estrada

*MotherCare Reproductive Health Project (health communication monitoring, in Spanish)*

March 26 – April 16, 1992  
Sonia Restrepo-Estrada

*MotherCare Reproductive Health Project (health communication monitoring, in Spanish)*

October 26 – November 7, 1992  
Sonia Restrepo-Estrada

*MotherCare Reproductive Health Project (health communication monitoring, in Spanish)*

March 18 – 29, 1993  
Sonia Restrepo-Estrada

# Indonesia

## *Social Marketing of Iron Folate Tablets*

### Background

Pregnant women in Indonesia have the lowest hemoglobin levels in Southeast Asia (World Health Statistics, 1982); other studies estimate that 70 percent of pregnant women in Indonesia are anemic. Recognizing the detrimental effects of anemia on maternal health and fetal growth, the Indonesia Ministry of Health has implemented a policy to distribute iron supplements through health centers (*puskesmas*) and community health posts (*posyandu*) to all pregnant women during their last trimester of pregnancy. But evidence shows that only one-third of pregnant women receive such supplements, mostly because of supply problems and they do not receive formal prenatal care. Further research done to find ways to overcome these problems show that traditional birth attendants (*dukun bayi*) cater to approximately 80 percent of all births in Indonesia, also provide some type of prenatal care and can be an important source of information and service for pregnant women.

### The Program

The University of Indonesia Center for Child Survival designed an operations research project investigating ways to improve women's consumption of iron folate tablets. The operations research study used a social marketing approach to overcome the problem of poor consumption by focusing on (1) the feasibility of distributing iron folate tablets to pregnant women through traditional birth attendants (TBA) among 10,000 households in Indramayu, West Java; and (2) complementing the distribution with a health communication component promoting coverage and compliance.

Specifically, this study was designed to test the effectiveness of an experimental community-based iron folate distribution system (in sub-district Gabus Wetan, the treatment area) to increase the availability and thus prenatal consumption of iron folate tablets, compared to the standard government clinic-based distribution system (in Sliyag, the control area). The first stage of this project entailed assuring the adequacy of iron folate tablet supplies and the distribution of tablets by the TBAs to the pregnant women from the TBAs' homes in the treatment area.

The second stage of the project, a health communication campaign, was launched nine months later in both the control and treatment areas to encourage women to use prenatal care services, to take iron folate tablets during pregnancy and to overcome compliance issues such as experiencing side effects and not being resupplied with tablets.

### **Formative Research**

Focus group discussions, in-depth interviews and behavioral trials (product and concept testing) were conducted by the project team with support from expatriate consultants with pregnant women, their husbands and elder female family members, their TBAs, and midwives and doctors of the formal health sector, to determine:

- ideas about anemia and blood during pregnancy;
- information on pregnant women's understanding and use of iron folate tablets;
- acceptability by pregnant women and TBAs of distributing iron folate tablets through TBAs; and
- appropriate channels of communication to distribute information and messages about the importance of iron folate tablets, how to consume them and where to get them.

Product trials were conducted with pregnant women to determine the palatability of iron folate tablets and women's ability to take a daily dosage as part of their daily routine.

Research indicated that the lack of availability of iron folate tablets and the lack of knowledge about iron folate tablets were the major obstacles to iron supplementation efforts. The research also reconfirmed that traditional birth attendants are important sources of support for pregnant women. Several revelations from the research aided in the design and development of a social marketing program.

- Maternal anemia is not perceived as a priority health problem by pregnant women, their families, or their traditional and formal health care providers.
- Factual knowledge of the need for and benefits of iron folate tablets is low at the community level and among traditional and formal health care providers.
- Pregnancy and related problems are not discussed openly in the family or community. Pregnant women's activities outside the home and rice field and their exposure to mass media other than radio are limited.
- Side effects and undesirable iron folate tablet characteristics are common causes for discontinuing consumption. Social support from family influentials and health care providers could increase compliance with consumption.
- Distribution of iron folate tablets through TBAs' homes (pregnant women visiting the TBA's home) rather than house-to-house (TBAs visiting pregnant woman's home) was more acceptable by pregnant women and by TBAs. However, the community does not perceive TBAs as a source of information about or services offering formal health care; some TBAs are also reluctant to become distributors of "modern" medicine.
- Household trials with pregnant women revealed that women took the iron folate tablets with food (either a snack or during a meal) to mask the less than tasteful tablet but also as a reminder to take the tablet.

## Strategy Formulation and Development

The University of Indonesia designed and implemented a social marketing program (1) to raise awareness among pregnant women of the importance of taking iron supplements; (2) to promote iron folate tablets and their distribution by TBAs and the formal health sector; and (3) to provide information on how to decrease side effects of the tablets.

Based on the research results, a multi-media plan was developed by the project team and a local advertising company to promote an understanding among pregnant women, their

families, and their traditional and formal health care providers of the importance of taking iron folate tablets, how to take them and where to get them. Specifically, the plan included the following:

- a counseling flipchart for midwives, community health volunteers and TBAs to better inform pregnant women of the importance of combatting anemia, why iron folate tablets would help, what to expect initially and to continue to take them even if they feel better, and where to receive more tablets;
- for easier distribution by TBAs, repackaging of tablets into small plastic sealable bags with the project's promotional sticker on the outside;
- take-home action cards for pregnant women to remind them to take iron folate tablets daily;
- poster, banners, stickers, tin plates, and balloons as special event promotional items, as well as markers for iron folate tablet distribution points (e.g., health centers, community health posts, TBA homes);
- radio advertisements featuring a pregnant woman named "Ibu Sehat" ["Madame Health"] and her supportive husband summarizing the rationale for pregnant women to take iron folate tablets and where to get them;
- "Iron Folate Tablet Awareness Days" scheduled monthly at health centers and community health posts; and
- periodic community meetings with men and community leaders to talk about and distribute leaflets on the importance of maternal health and, specifically, iron folate tablet consumption.

Messages were designed in accordance with formative research findings and pretest results of the materials. The project's "spokesperson," "Ibu Sehat," appeared in the print and radio material as a unifying element; use of such a figurehead ensured a continuity and rallying point among the variety of activities under the program.

## **Implementation and Monitoring**

The multi-media program was launched with district and local health officials and community leaders. Traditional and modern health care providers were trained in the use of the counseling materials. Their training provided a forum to distribute the print materials. The radio spots were then aired.

Monitoring activities included field observations, in-depth interviews and examining data from an operations research survey being conducted among pregnant women at intermittent times during their prenatal and postnatal periods. Initial observations revealed interesting programmatic issues:

- Iron folate tablets in one project site became discolored and began to crumble after being distributed to pregnant women. In an attempt to reduce this deterioration, small plastic bottles (donated by Bristol-Myers Squibb) were given to pregnant women to store their tablets.
- Midwives stated that using the counseling flipchart with pregnant women would reduce the midwife's own clinical credibility for two major reasons:

- Overtly referring to illustrated cards may give the impression that midwives themselves need help in understanding anemia and iron supplementation.
- Using counseling cards that are also used by TBAs and community health workers “reduces” the midwife to the level of the other health care providers who are not as well trained.

As a result, midwives were not using flipcharts. Community health volunteers had also stopped using flipcharts, feeling awkward using a print material that was openly scorned by their supervisor.

In order to mollify this feeling, midwives were given additional orientation as to how the counseling flipcharts were developed, for what audience they are meant (e.g., pregnant women), and the importance of health workers using the counseling flipcharts. Flipcharts were also disassembled and pasted onto the wall of the clinics where counseling takes place so that midwives could more discretely refer to the cards without feeling inadequate.

## ***Findings and Future Directions***

In the treatment area, making iron folate tablets available via the TBAs in the community to pregnant women, and ensuring an adequate supply of tablets significantly increased the availability, coverage and consumption of iron folate tablets. Health communications to increase use of services and iron folate tablets did not significantly increase coverage and compliance above and beyond the effect of the distribution system. However, in the control area, where adequate supply of tablets were available but the distribution was through regular government channels, both coverage and compliance with the iron folate regime were significantly increased after the health communication campaign.

Before the communication campaign, women in the control area reported taking a total of approximately 28 tablets during pregnancy, compared to 45 tablets after exposure to the campaign. In the treatment area, the difference was minimal, approximately 70 tablets after the communication campaign compared to 65 tablets before, a change which was not significant. However, even in the treatment area with the combined interventions (communications and community-based distribution), the number of iron folate tablets taken throughout pregnancy is still far below the number needed to adequately prevent anemia.

In terms of the proportion of women reporting iron folate tablet use in this pregnancy, only 53 percent of the women in the control area reported taking iron folate tablets in their pregnancy before exposure to the communication campaign. This increased significantly to 86 percent after exposure to communications. This difference was minimal in the treatment area (92 percent before the communication program but after the enhanced distribution, and 98 percent after the communication program), as coverage was almost universal prior to the campaign as a result of the new TBA distribution system.

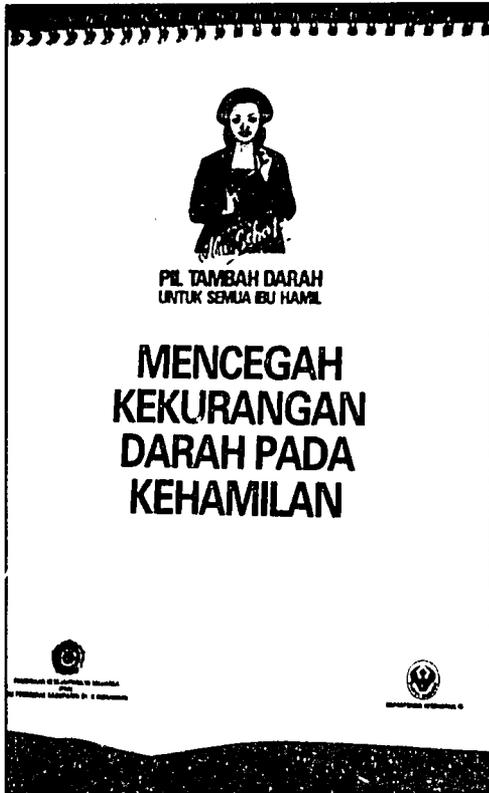
These results imply that promotion of TBA tablet distribution and a health communication campaign focused on increasing compliance (recommended daily consumption) could be an effective strategy for improving iron folate status in Indonesia and elsewhere where anemia is prevalent. However, project implementors feel the health communication component should have spent more time convincing women and their families that anemia is a problem that requires continuous action.

Several lessons have been learned to help better design social marketing programs and health communication materials:

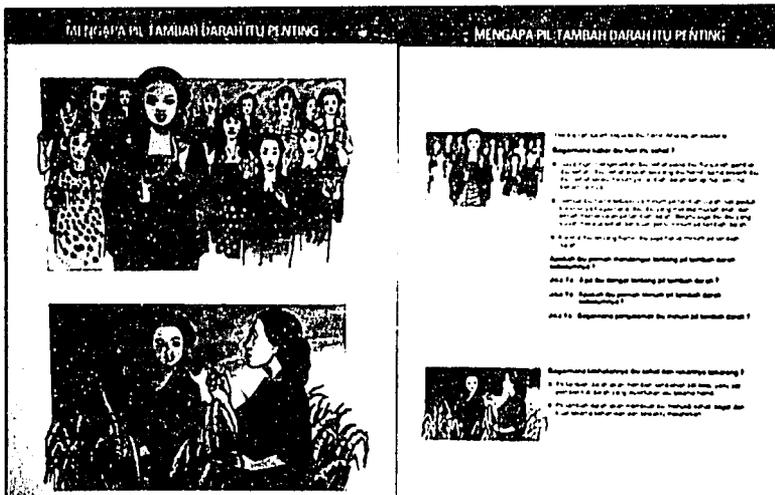
- Qualitative research can help define overall program strategy, i.e., distribution systems in addition to factors important in health communication. In this case, selection and testing of TBA networks was critical to resolving the iron folate tablet supplementation problem.
- Messages about signs and symptoms of anemia to raise awareness about anemia and its importance to maternal health may be unnecessary in increasing coverage; people seem willing to take the supplement if provided.
- Education and enhanced distribution individually achieve impact. More work is needed on the synergism of those two factors to achieve better results.
- Test the product being promoted for shelf-life, palatability and other determinants of quality.
- Ensure that promoters of messages are properly and thoroughly oriented in the purpose of the messages and the use of materials. Do early, frequent monitoring to check on materials use and message comprehension.
- To achieve synergism of health communication and distribution systems, qualitative research will be needed prior to enhancing distribution and after it is allowed to function over a period of time before developing a health communication campaign meant to supplement its coverage.

The Indramayu project has become one of the pilot projects among several the Government has launched to help design a national iron folate supplement program to help combat anemia. The Government has indicated interest in reproducing some of the health communication materials for other areas.

# Indramayu, Indonesia Health Communication Materials



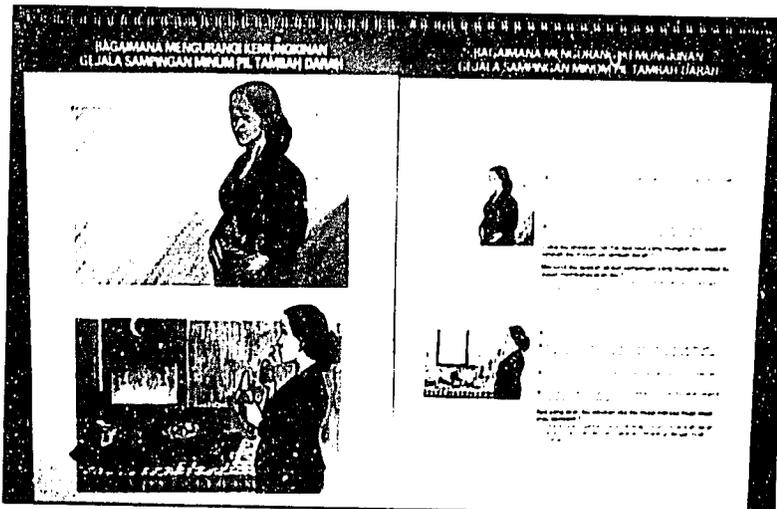
A. Counseling Cards (Flipchart) for Use by Health Workers with Pregnant Women who Need Iron Folate Tablets



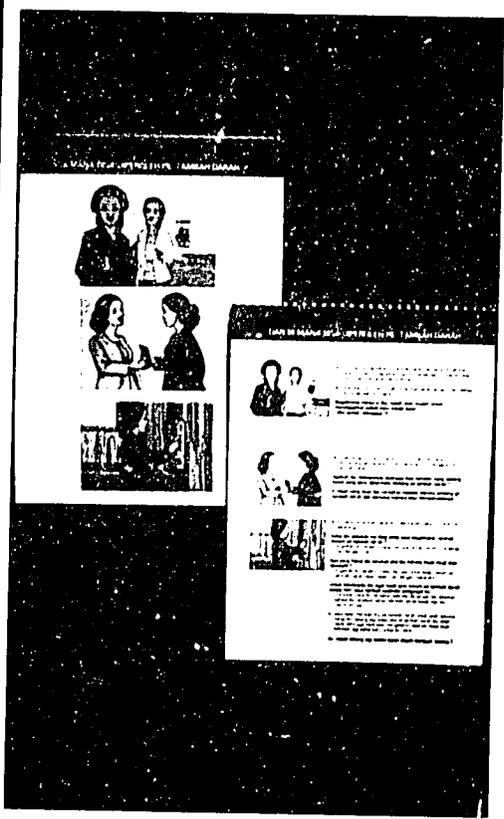
A1. Why to take iron folate tablets and who should take them



A2. Where to get iron folate tablets and when to take them



A3. Possible side effects from iron folate tablets and what to do about them

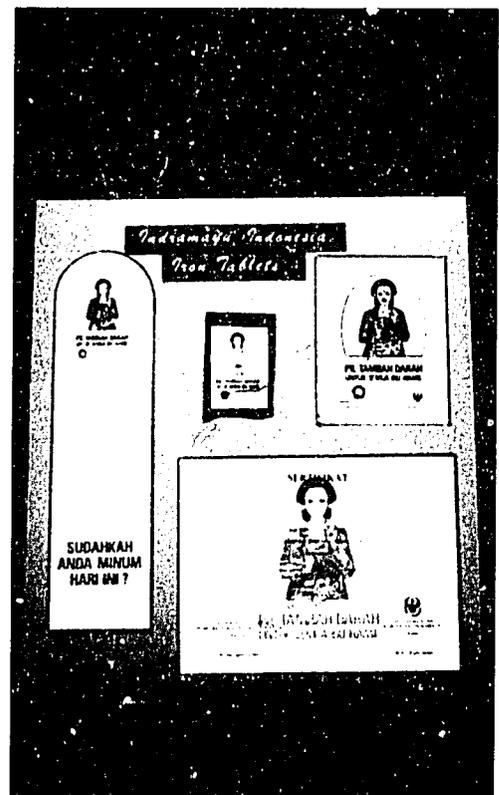


A4. Reminder where to get iron folate tablets, who should take them and when



B. Poster Promoting the Consumption of Iron Folate Tablets and Their Distribution by Traditional Birth Attendants (Dukun Bayi)

C. Supplementary Print Materials:  
 Take-home Reminder Card; Packet of Iron Folate Tablets; Promotional Decal; Certificate of Merit for Health Workers and TBAs Trained in Use of Counseling Cards



## **Bibliography: Indonesia (Indramayu)**

1. For further information and copies of the original health communication materials produced under the health communication component of this project, please contact:

**University of Indonesia Center for Child Survival**

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2. For copies of the following reports, please address inquiries to:

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Attn: *Marcia Griffiths, President*

## **Special Reports**

MotherCare Final Report

Indramayu Final Report

## **Working Papers**

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Working Paper 2

November, 1990

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*Interventions to Improve Maternal and Neonatal Health and Nutrition*

Working Paper 4

December, 1990

Niki George

*The Prevalence of Anemia in Developing Countries, 1979-1989—An Annotated Bibliography*

Working Paper 7A  
February, 1991  
Elizabeth A. Jordan  
Nancy L. Sloan

*Prevalence of Maternal Anemia in Developing Countries*

Working Paper 7B  
April, 1992  
Nancy L. Sloan  
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Siti Pariani

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Marcia Griffiths  
Mona Moore  
Michael Favin

*Does Iron Supplementation Make A Difference?*

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Nancy L. Sloan  
Elizabeth A. Jordan  
Beverly Winikoff

**Trip Reports**

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January 9 – 31, 1991  
Mona Moore

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May, 1991  
Mona Moore

*Improved Iron Folate Distribution to Alleviate Maternal Anemia, Indramayu, West Java: Analysis of the Qualitative Research Results and Preparation of the Research Report.*

April 22 – May 18, 1991  
Mona Moore

*Preparing the Communication Plan: Improved Iron Folate Distribution to Alleviate Maternal Anemia in Two Sub-districts of Indramayu Regency, West Java, Indonesia*

July, 1991  
Richard Pollard

*Indramayu Communication Strategy*

September 16 – October 12, 1991  
Carolyn Hessler-Radelet

*Indramayu Social Marketing*

September 16 – October 5, 1991  
Richard Pollard

*Indramayu Operations Research Project to Reduce Anemia in Pregnant Women: Progress and Future Plans*

February, 1992  
Marcia Griffiths

*Indonesia Iron Folate Distribution Information, Education and Communication Campaign: Pretest, Training, Launch*

July, 1992  
Carolyn Hessler-Radelet

# Indonesia

## Community-Based Birthing Huts

### Background

While Indonesia has been successful in lowering fertility through family planning, the maternal mortality ratio remains high at about 450/100,000 live births. A study conducted in the West Java subdistrict of Tanjungsari (Bandung) in 1988-89 revealed that most maternal deaths occurred due to delays in obtaining services for obstetrical emergencies. The three most common reasons for delay cited by women and health staff were:

- delays by pregnant women and their supporters (husbands and traditional birth attendants) in making timely decisions to move to a higher level of care;
- delays in actually accessing an appropriate health care facility (due to transportation problems, cost and distance); and
- delays, due to inadequate health facility equipment and staff skills, in receiving appropriate care once accessing the health institution.

To help address this problem, in 1989 the Government of Indonesia decreed that midwives should be trained and placed in all 87,000 villages as part of its goal to address obstetrical emergencies at the community level.

### The Program

The University of Padjadjaran (in Bandung) developed an operations research project to address these issues of referral and attendance for emergencies. The intervention area, the subdistrict of Tanjungsari, established ten birthing huts (*polindes*) at the village level where women can go for prenatal care screening, referral and deliveries. Some birthing huts were established in TBAs' homes, some stood alone, while others were attached to the home compound of a village leader. All huts provided improved communication (a two-way radio) with higher levels of obstetrical emergency care—three health centers and a referral hospital. An ambulance was also maintained at the health center in readiness to provide transport from the birthing huts to health centers or the hospital. The birthing huts were visited on a routine basis by a midwife and were maintained and informally staffed by village TBAs.

The objectives of this project were to:

- increase awareness of the importance of prenatal care and the recognition of delivery complications among the provider and the community;
- provide appropriate maternal care services at the community and district levels;
- strengthen the communication and information networks for the formal and informal sectors of the health delivery system; and

- over the long term, develop a replicable model for appropriate maternal care.

Subsequent to the establishment of the birthing huts, the project felt a health communication strategy would be important to improve the awareness and responsiveness of women, their husbands and TBAs concerning the purpose of the birthing huts and timely recognition of danger signs and referral.

## Formative Research

To prepare the needed health communication component, focus group discussions and in-depth interviews were planned by the project team with expatriate assistance. The research was done with pregnant (or recently delivered) women, their husbands, their traditional birth attendants, community leaders and midwives with and without experience with a birthing hut. Among others, the following topics were explored:

- the experience with self-care and health care-seeking during pregnancy and delivery by women, their husbands and TBAs;
- knowledge and recognition of danger signs and complications during pregnancy and delivery, and responses in seeking and providing health care; and
- knowledge and attitudes toward the newly established birthing huts—why they exist, whether they are appropriately designed, equipped, staffed and placed, and whether their services are helpful.

Some of the key results from the research assisted not only in designing a health communication campaign but also in offering guidance to relocate the hut or change the staffing and services offered by birthing huts to better meet the needs of the clientele. However, most of the results were used only to promote the existing birthing huts and the timely recognition of when to use them for routine and emergency care.

Following are some important findings from the research:

- Pregnancy is not generally viewed as a debilitating condition, nor one that requires much alteration of one's daily lifestyle. Conditions recognized by respondents to be dangerous during pregnancy include malposition, bleeding, high blood pressure and anemia. Short stature and swelling of feet or legs in the last trimester are not considered risk conditions.
- Pregnant women generally use both formal and traditional health care systems for prenatal care. Formal health care is provided by trained midwives and doctors at the birthing hut, health center or hospital. Most women reported examination by a midwife at least once during their pregnancy. TBA care is sought by almost all women from the seventh month of pregnancy until forty days postpartum.
- Women report a strong preference for home births attended by a TBA and other family members. Delivering at home maintains the "link with life and living."
- Prolonged labor is not mentioned as a dangerous condition. Labor is normally seen to appear and pass quickly. "One hour" was frequently mentioned as the duration of labor.

- Respondents are somewhat ambivalent towards the birthing huts. The huts are valued for their regular provision of prenatal care and for offering emergency access to a midwife or doctor. However, several points were raised concerning their placement and design:
  - Most respondents are uncomfortable, to the point of embarrassment (especially in regards to delivery), with the placement of some of the huts in the home compound of the village leader or TBAs other than their own because of the implications for personal as well as financial indebtedness.
  - The small size of the hut may prohibit a family from attending the birth. The beds in the huts are unfamiliar to women in delivery because a mat and the squatting position is the more common means of delivering.
  - Birthing huts are placed on roadways in order for ambulances to have access to them; this does not necessarily make the huts more accessible to the community.
- Cost of transport and emergency services and poor road conditions inhibit compliance with referral unless the woman and her family accept referral as the only means to preserve the life and health of the woman and baby.

## Strategy Formulation and Development

A one-week workshop was conducted to develop health communication strategies. However, prior to developing the strategy, it was important to define the following:

**Risk:** It was unclear whether a pregnant woman at low risk should be asked to deliver at the birthing hut, because just getting there may put her at higher risk. Therefore, birthing huts would be promoted as one option for where pregnant women could go for delivery because of its access to an ambulance and emergency care. TBAs are also encouraged to use birthing huts if their clients decided to deliver at home but had complications. Concurrently, referral of medium- and high-risk pregnant women to hospitals for delivery is promoted.

**Cost:** Costs for using birthing huts had not yet been standardized. Some village leaders charged for using the hut. And, TBAs managing the hut also charged for their attendance, as did the pregnant woman's own TBA who would accompany the woman to the hut. Midwives in attendance or called for an emergency also added to the payment schedule, making the cost of a birthing hut on occasion more expensive than using the services of a more distant health service, but one with emergency equipment, supplies and staff. Meetings with village leaders were conducted and a standard fee with a rolling scale based on ability to pay was implemented. The health communication campaign could now promote the birthing hut's service as "affordable and within the means" of the community.

Once the above questions were answered, the following content was developed into the program's key messages:

- Importance of attending prenatal care:
  - attend at least four times:
    - to verify pregnancy;*
    - to receive two separate tetanus shots;*
    - to receive a final check-up during the last month of pregnancy;*
  - when you are feeling sick or experience any of the pictured conditions (i.e., danger signs).
- Where to get prenatal care:
  - The birthing huts as well as three other government health services were promoted. Particular emphasis was placed on attending the hut when a midwife or government-trained TBA was in attendance.
- Why a birthing hut is convenient and attractive to visit and utilize for prenatal care and delivery (i.e., due to access to emergency care).
- When to take the "first step" to a place where a pregnant woman has decided to deliver (i.e., early on, when labor contractions—called "mulas-mulas"—are first noticed, or when complications set in). Coupled with this message was the explanation of why it is important to follow the advice of the midwife or TBA regarding the place to deliver.
- Why a birthing hut can be a safer place to deliver than at home if a woman takes her "first steps" during the onset of labor contractions.

## Implementation and Monitoring

A health communication team was created from the project team and an on-site expatriate consultant provided weekly support to the team in designing materials and implementing the strategy. Their efforts were supplemented by visits by expatriate consultants. Promotional leaflets for pregnant women, husbands and TBAs were developed to address the above issues. Pregnant women received reminder cards depicting danger signs and complications and encouraging women to seek help if they experience them. TBAs were also given leaflets helping them recognize danger signs and complications.

The health communication component was launched with a series of marches and parades from the center of Tanjungsari out to the ten birthing huts. Competitive tests of knowledge about danger signs and complications and the purpose of birthing huts were held with TBAs from the participating villages. "Open House" days were also conducted every month at each birthing hut to further expose the community to the purpose and design of the birthing hut. Use of the two-way radio and the presence of the ambulance and midwife were a key part of the events.

Monitoring, using focus group discussions and observations, showed that:

- Women did not care for take-home materials that depicted danger signs and complications, as they believed these illustrations would be prophetic.
- Women also felt that knowing about danger signs was important, but thought, if the danger sign (e.g., edema) didn't hurt or was a common occurrence during pregnancy and disappeared after delivery, or didn't inhibit everyday chores, that it could not be very dangerous.
- TBAs felt uncomfortable referring more than the "usual" number of clients to a birthing hut; they felt it undermined their "medical authority" in the eyes of the community. However, the community in general respected the decision of the TBA in terms of referral for danger signs and complications.

## ***Findings and Future Directions***

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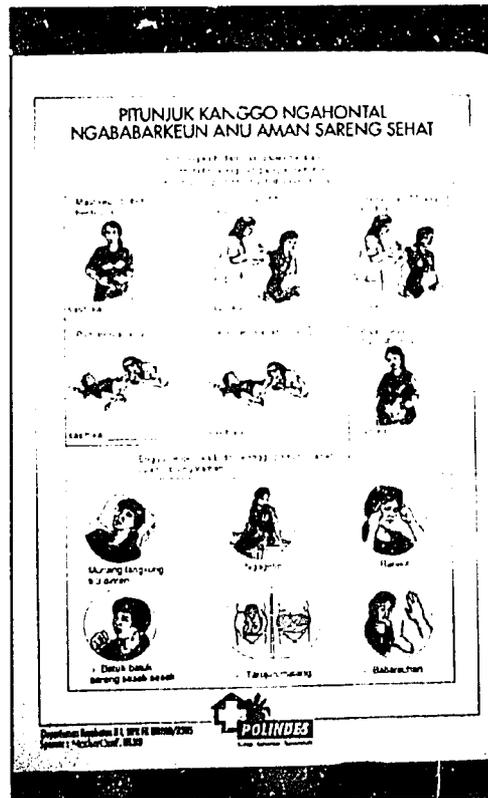
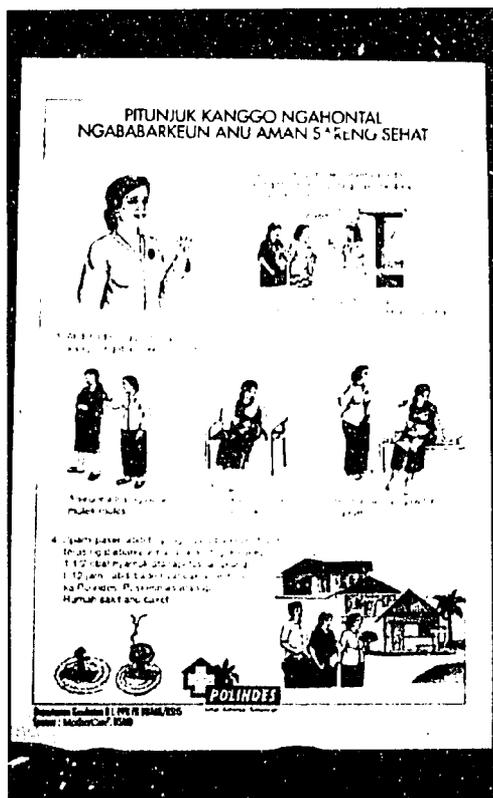
- The community needs to be involved in the design, placement and costing of community-based birthing huts. The community will not only feel a sense of responsibility toward maintaining the birthing hut, but will also be more inclined to use it.
- Increasing knowledge and attitudes towards birthing huts will not increase use if the birthing huts do not conform to the needs of pregnant women. A health communication campaign without concurrent constructive changes in the service and product it is promoting will do little to affect behavior.
- Birthing huts are viewed as valuable because they provide prenatal services, but few pregnant women use them for delivery. Birthing huts as designed cannot compete with the value associated with home delivery.
- Although TBAs consider referring clients to another facility, such as a birthing hut (managed by other TBAs), as a discredit to their own professional standing in the community, referrals from TBAs to *Polindes* increased from 19 percent to 53 percent for prenatal women and from 17 percent to 33 percent during labor/delivery over a six-month period following the launch of the health communication campaign. TBAs and the community need to be reassured that referral is life-saving and is a very respectable decision on the part of the TBA.

The Tanjungsari project has been thoroughly written up in reports and articles. Presentations have also been made to the Government of Indonesia so that future regional and national programs promoting community-based birthing huts can benefit from Tanjungsari's experiences.

# Tanjungsari, Indonesia Health Communication Materials



A. Posters Promoting the Use of Community-based Birthing Huts



B. Take-home Action Posters for Pregnant Women: Danger Signs and Complications  
(continued on next page)



**B. Take-home Posters**  
*(Continued from previous page)*



**C. Take-home Leaflets for a Pregnant Woman, Her Husband and Her Traditional Birth Attendant (TBA)**

**C1.** For the pregnant woman, emphasis on using birthing huts for routine prenatal care and when experiencing danger signs or complications



**C2.** For the husband, emphasis on benefits of birthing hut's access to emergency care



C3. For the TBA, emphasis on the use of birthing huts and when their clients should use them

## **Bibliography: Indonesia (Tanjungsari)**

1. For further information and copies of the original materials produced under the health communication component of this project, please contact:

**University of Padjadjaran**

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*Attn: MotherCare Publications*

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*Attn: Marcia Griffiths, President*

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*Communicating Safe Motherhood: Using Communication to Improve Maternal Health in the Developing World*

Working Paper 14  
November, 1991  
Marcia Griffiths  
Mona Moore  
Michael Favin

*Qualitative Research for the Social Marketing Component of the Perinatal Regionalization Project*

Working Paper 19  
November 1991  
Dr. Nanet Prihatini Ambaretnani  
Carolyn Hessler-Radelet  
Leslie Carlin

**Trip Reports**

*Development of the Social Marketing Component of a Project to Alleviate Maternal Anaemia in Indramayu. Review of Possible Social Marketing Activities in the Perinatal Regionalization Network Project in Tanjungsari*

January 9 – 31, 1991  
Mona Moore

*Development of the Social Marketing Component of a Perinatal Regionalization Project in Tanjungsari: West Java*

May 20 – 27, 1991  
Mona Moore

*Research Plan and Research Instruments: Perinatal Regionalization Project in Tanjungsari, West Java*

September 23 – October 12, 1991  
Gisele Maynard-Tucker

*Tanjungsari Perinatal Regionalization Project: Progress to Date and Future Plans for Communication Component*

February, 1992  
Marcia Griffiths

*Tanjungsari Trip Report #8 (health communication strategy development)*

August 18 – 29, 1992  
Kim Winnard

# *Kenya*

## *Preventing Congenital Syphilis*

### *Background*

Between 7 and 10 percent of pregnant women in Nairobi, Kenya test positive for syphilis; if these women are untreated, one-fourth of their pregnancies would end in miscarriages or stillbirths while another one-third would lead to congenital infection. Screening and follow-up treatment for pregnant women attending prenatal care clinics are separated by time and location. Pregnant women have had to wait up to two weeks for test results (if tested) and were usually asked to go (if they came back for test results) to a central location for treatment. Results (University of Nairobi, 1989) were predictable:

- 60 percent of prenatal care attenders were actually screened for syphilis;
- 9.1 percent of those who tested positive for syphilis were treated; and
- less than 30 percent of partners who tested positive for syphilis were treated.

### *The Program*

The University of Nairobi and the University of Manitoba, under a grant from the Canadian government, were already involved in strengthening preventive activities related to the prevention of congenital syphilis in three Nairobi City Commission (NCC) public health clinics. Training, drug supplies and supervision were given to participating prenatal clinic staff in order for them to provide all attending pregnant women on-the-spot screening using the Rapid Plasma Reagin (RPR) syphilis test and immediate treatment. Partners would be contacted through the women by a slip of paper notifying them to come to the clinic for consultation.

MotherCare recommended expanding the number of NCC clinics to 10 and placing more emphasis on the health communication component. The initial program objectives were to:

- increase the proportion of pregnant women who seek prenatal care before 20 weeks of gestation;
- increase the proportion of pregnant women screened for syphilis at the prenatal clinics;
- raise the percentage of RPR positive pregnant women receiving treatment;
- increase the numbers of partners notified and treated;
- study health-seeking and health-providing behavior during pregnancy and factors that influence these behaviors; and
- study the effectiveness and cost-effectiveness of the interventions.

## Formative Research

Intensive qualitative research was conducted by the project team and a local consultant with pregnant women (those infected and uninfected), their partners and their service providers to determine the factors that motivated, inhibited and enabled health care-seeking and -providing behavior and compliance with treatment and prevention of re-infection of syphilis. Findings from quantitative monitoring and qualitative research revealed the following patterns of knowledge, attitudes and behavior among clients and their partners:

- Syphilis is neither known nor well understood as a distinct disease by many clinic attenders and their partners.
- The percentage of women coming for their first prenatal care check-up prior to or at 20 weeks of pregnancy is about 18 percent. Most women felt that five or six months is "early" and attendance is usually initiated because of feeling ill.
- Communication between women and their partners about sex and sexually transmitted diseases is wrought with potentially volatile reactions. Women telling men that they share an STD implies that one or both are having sexual relations outside of their own relationship. This revelation may bring vulnerability, accusations, denial, hostility and disintegration to a social and economic relationship that may have been relatively stable.
- Condom use carries the stigma of being used "outside" of a relationship; condom use with one's "primary" partner is problematic.
- Motivating reasons for partner compliance with treatment focus on the health of the unborn child. Barriers to compliance focus on denial of having the disease, especially when no symptoms are being experienced.

## Strategy Formulation and Development

The principal strategy contained in the health communication component was to enable counselors to negotiate with the client realistic behaviors to comply with treatment and prevention of re-infection, including notifying partners and motivating partners to seek treatment. Counselors also focused on helping clients better negotiate partner notification by role-playing how to tell partners that they are or may be infected, and what the pregnant woman can do if her partners deny having the disease or do not comply with treatment.

Community-based promotion of early prenatal attendance by pregnant women, an activity designed to address the first programmatic objective mentioned above, was not implemented in order to allow screening, treatment, and counseling services to be fully in place.

## Implementation and Monitoring

The health communication component developed a counseling training module to accompany the screening and treatment training module and protocols for use with prenatal clinic providers of NCC clinics. There are three sessions to the counseling module:

**Promoting Behavior Change**, which includes:

- values clarifications relating to a service provider's own sexuality;

- identifying motivating, inhibiting and enabling factors that influence syphilis transmission among clients and quality of care among service providers; and
- the role of service providers in promoting behavior change of the client and themselves.

**Counseling Women with Syphilis and their Partners**, which includes:

- verbal and non-verbal communication skills;
- what to say to clients when negotiating behavior change; and
- strategies for counseling "special needs" clients.

**Using Syphilis Counseling Materials**, which includes:

- the process used to develop client-oriented provider-friendly counseling materials; and
- role-plays on the use of counseling cards produced under this project.

Two distinct sets of counseling cards containing messages meant for a pregnant woman and messages meant for her partner(s) were developed for use by prenatal care service providers during counseling sessions. The cards helped service providers educate clients on the causes and symptoms of syphilis, how the disease is further spread unknowingly because people may not recognize its symptoms, and how to prevent reinfection, through condom use and sexual behavior change. Counselors were to make sure that realistic behavior change options were identified, discussed, negotiated and accepted by the client before leaving the counseling setting.

**Primary messages for RPR positive clients and their partners emphasize:**

- compliance with treatment (i.e., abstaining from sex or using a condom; notifying all partners).
- improved negotiation skills for pregnant women in notifying and then convincing their partners to seek treatment.
- how to protect the pregnant woman from getting reinfected if their partners do not comply with treatment.

Two take-home leaflets, one for the pregnant woman and one for her partner(s), were also developed to reinforce measures to prevent reinfection as well as to enable pregnant women to notify and encourage their partners to get treatment.

## ***Findings and Future Directions***

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Clinic data and qualitative interviews of clients and partners were utilized to identify trends of behavioral change among pregnant women and their partners. Over a five-month implementation period following the introduction of the new screening and treatment process (but prior to the introduction of counseling materials), results have been dramatic:

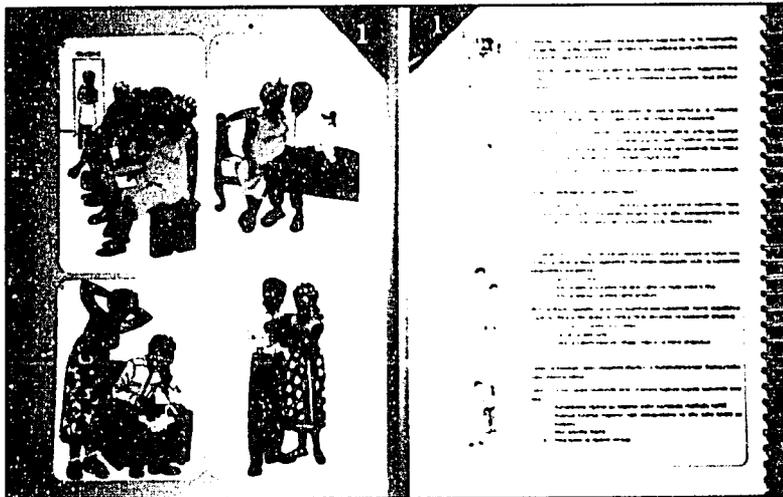
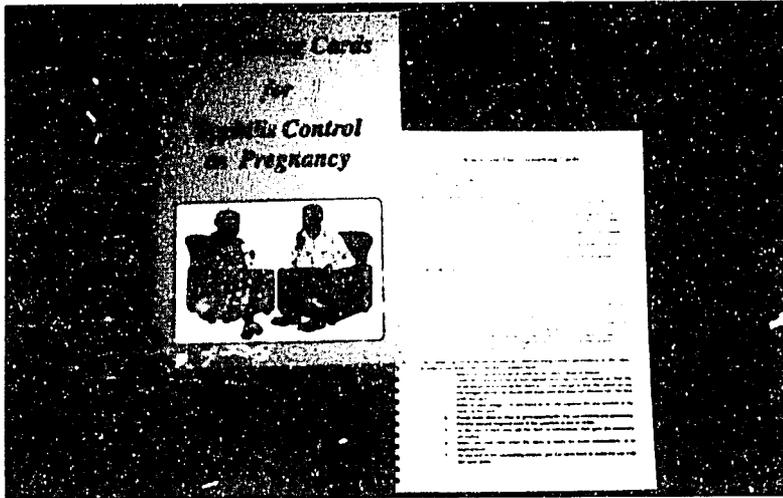
- 100 percent of prenatal care attenders were actually screened for syphilis;

- 86 percent of those who tested positive were adequately treated; and
- 52 percent of their partners (assuming one partner per positive pregnant woman) were treated.

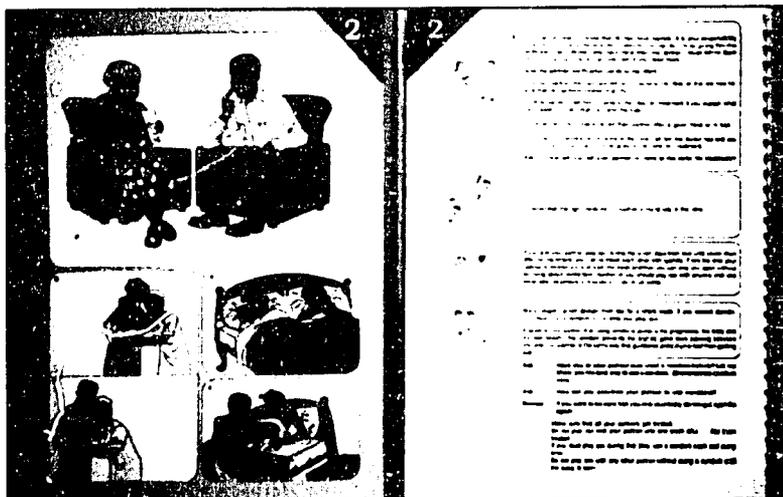
Kenya's congenital syphilis prevention project has already been requested by the Ministry of Health and the Nairobi City Commission (NCC) to expand activities throughout the NCC network and to other urban areas. But more time is needed to determine the effectiveness of the counseling and take-home materials. Also, the community-based promotion of early prenatal care attendance and general STDs prevention still needs to be implemented before the program is truly complete.

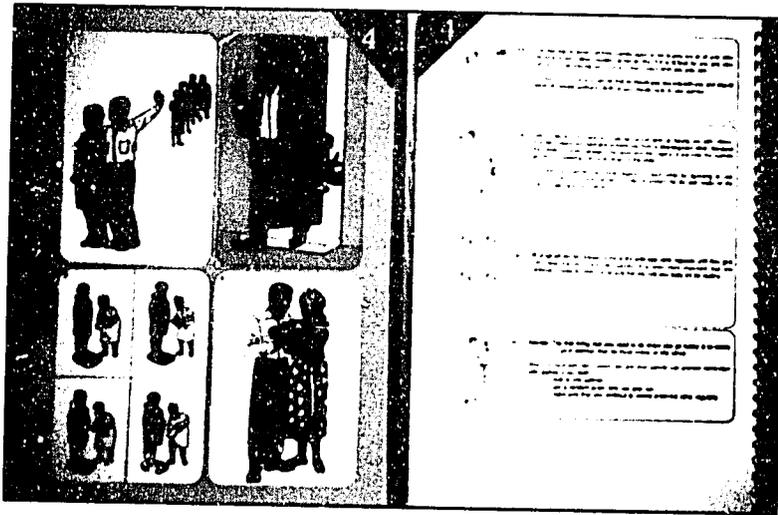
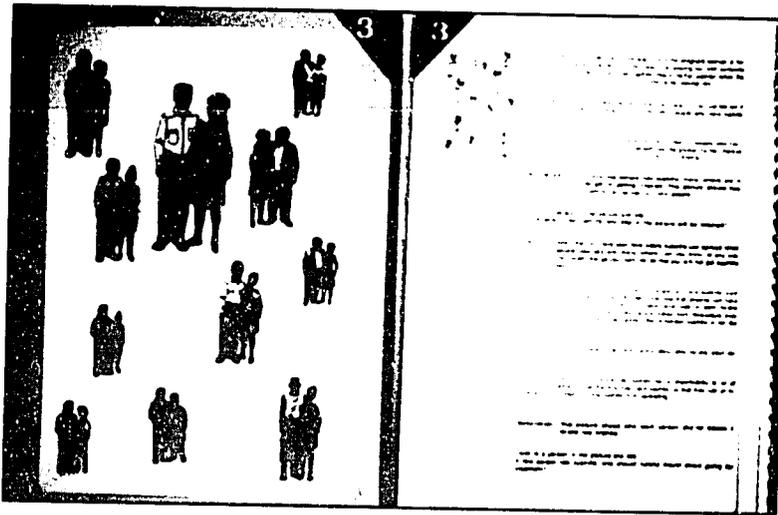
Meanwhile, there is also a strong interest by the Kenya government and by the University of Nairobi/University of Manitoba program to adapt the training modules, and counseling cards will also be adapted for use in screening, treating and counseling in other STDs, including HIV/AIDS, gonorrhoea and chlamydia.

# Kenya Health Communication Materials

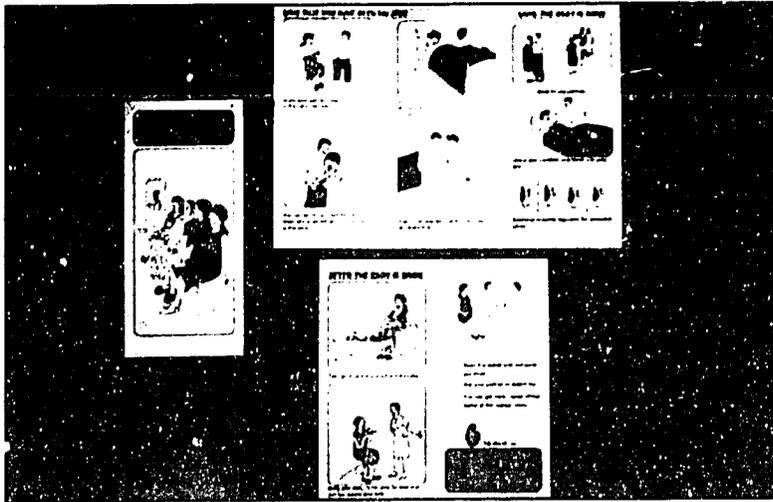


A. Counseling Cards (Flipchart) for Use by Health Workers with Pregnant Women Who Test Positive for Syphilis (continued on next page)

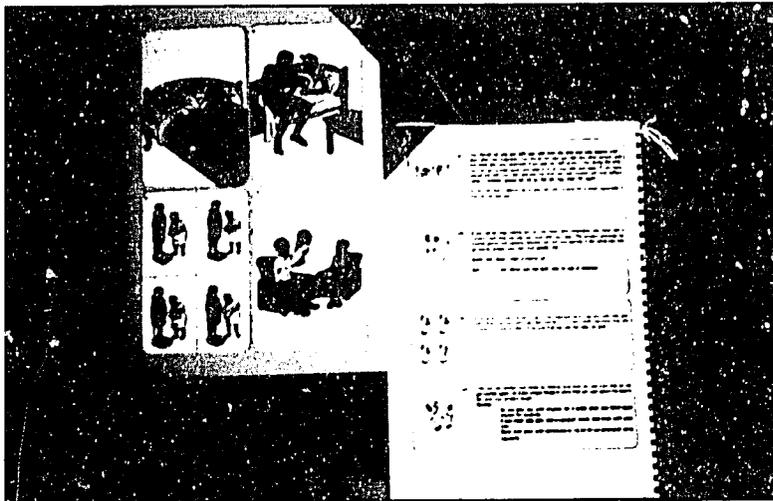




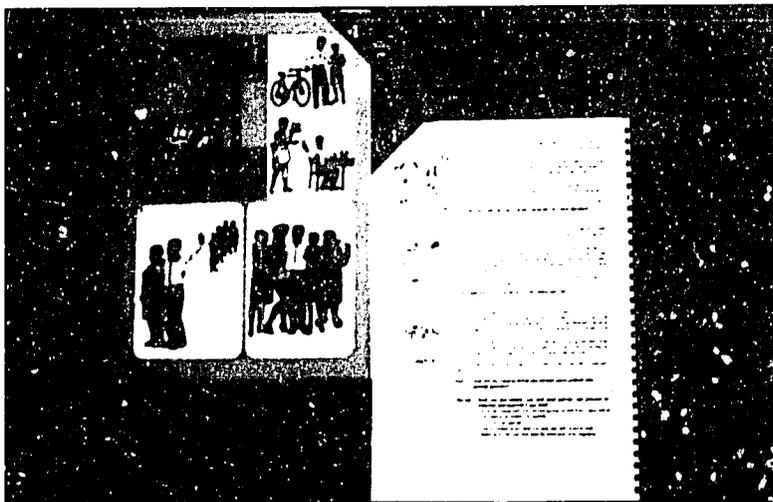
A. Counseling Cards  
 (continued from previous page)

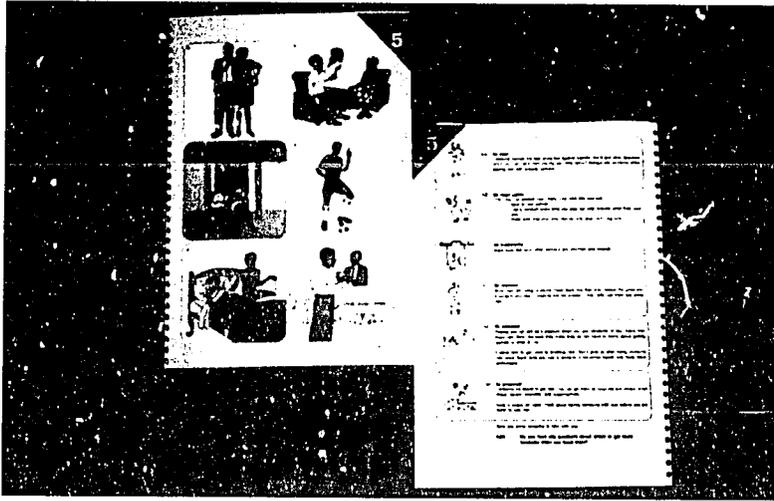


**B. Take-home Action Leaflets for Pregnant Women Treated for Syphilis**

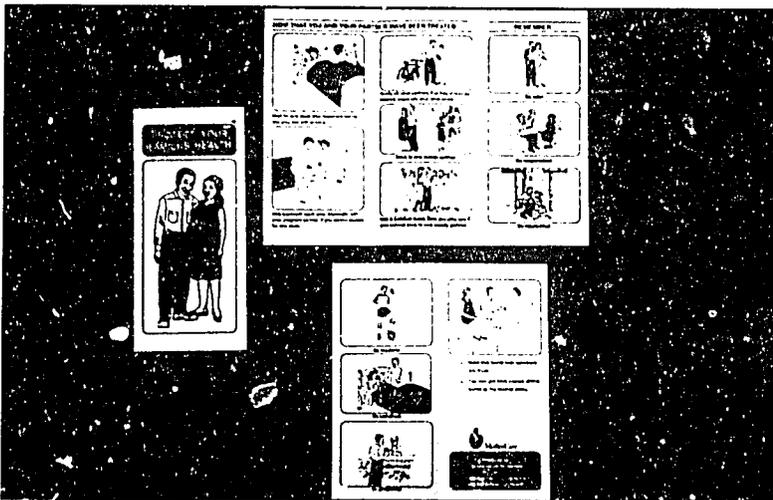
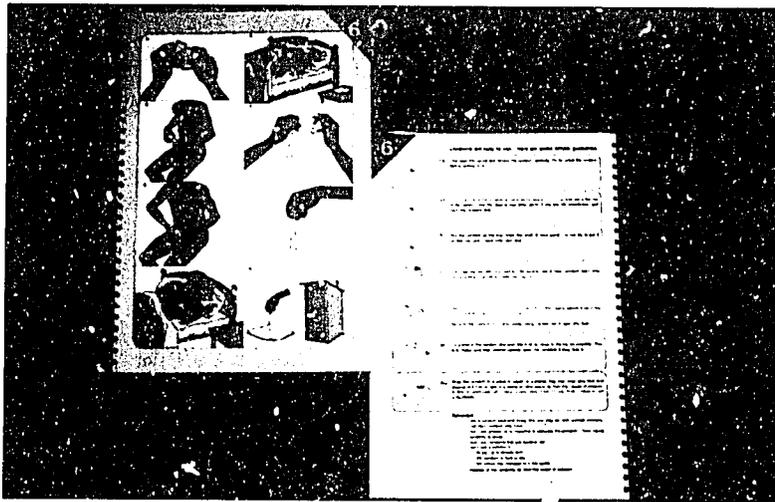


**C. Additional Counseling Cards Designed Especially for Use With Men Who Come in for Treatment for Syphilis** *(continued on next page)*





**C. Additional Counseling Cards**  
*(continued from previous page)*



**D. Take-home Action Leaflet for Men Treated for Syphilis**

## ***Bibliography: Kenya***

1. For further information and copies of the original materials produced under the health communication component of this project, please contact:

**Department of Medical Microbiology**  
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*Contact: Dr. Stephen Moses, Project Administrator, University of  
Manitoba/University of Nairobi MotherCare Project*

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**The Manoff Group**  
2001 S. St., NW, #510  
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## ***Special Reports***

MotherCare Final Report

Kenya Final Report

"Women, Infants and STDs: Opportunities for Action in Developing Countries." Reports of the Conference held in Rosslyn, Virginia. November, 1991. Joe Coyle and Sally Di Paula. Washington, D.C.: MotherCare Project, 1992.

*Screening, Treatment and Counseling Training Modules*

August 1993  
Nairobi, Kenya

## ***Working Papers***

*Behavioral Determinants of Maternal Health Care Choices in Developing Countries*

Working Paper 2  
November, 1990  
Mona Moore

*Interventions to Improve Maternal and Neonatal Health and Nutrition*

Working Paper 4  
December, 1990  
Niki George

*Communicating Safe Motherhood: Using Communication to Improve Maternal Health in the Developing World*

Working Paper 14  
November, 1991  
Marcia Griffiths  
Mona Moore  
Michael Favin

*Maternal/Congenital Syphilis Control Project: Qualitative Research Report*

Working Paper 16  
August, 1993  
Donna K. Pido

**Trip Reports**

*Refinement of Proposal Submitted by University of Nairobi on Congenital Syphilis Prevention in Nairobi City Commission Public Health Clinics*

March 18 – April 1, 1992  
Kim Winnard

*Congenital Syphilis Prevention Project, Review of Project Design and Refinement of Communication Component*

August 3 – 27, 1993  
Mona Moore

*Congenital Syphilis Prevention Project, Development of Clinic-Based IEC Materials*

February 2 – 25, 1993  
Mona Moore

*Information, Education, Communication Activities with University of Nairobi Congenital Syphilis Prevention Program*

February 14 – March 10, 1993  
Pamela Greene

*Trip Report (development of counseling training module)*

May 24 – June 12, 1993  
Pamela Greene

# *Nigeria*

## *Strengthening Midwifery Services*

### *Background*

According to hospital reports and National Population Commission projections, the maternal mortality ratio in Nigeria ranges from 600-1500/100,000 live births with appreciable variation seen between urban and rural areas and between southern (predominantly Christian) and northern (predominantly Muslim) zones. A senior tutor, in a recent presentation at Lagos University Teaching Hospital, reported that about 75,000 Nigerian women die yearly from pregnancy-related causes. Moreover, for every woman who dies, 20 more are debilitated through subsequent disease and disability.

### *The Program*

MotherCare worked with the Federal Ministry of Health and the state ministries of health in the southern state of Oyo/Osun (during the initial days of the project, Oyo state was administratively divided into Oyo and the newly created Osun state) and the northern state of Bauchi to strengthen the quality of maternal care services, particularly prenatal/labor and delivery services. To this end, the project upgraded clinical knowledge and skills ("life-saving skills") of practicing government midwives to manage obstetrical emergencies.

The health communication component at the service level focused on introducing counseling (interpersonal communication skills) as an additional "life-saving skill" for midwives and traditional birth attendants. Community-based health communication activities would concentrate on the following efforts:

- reinforcing positive and redirecting negative self-care practices among pregnant women, their husbands and their traditional healers and birth attendants;
- promoting an awareness of how to recognize danger signs and complications during pregnancy and delivery; and
- motivating pregnant women and their supporters to use the newly enhanced midwifery services on a routine (prenatal care) and emergency basis.

A national policy meeting was held at the onset of the project with representatives from the Federal Ministry, state governments, the state training centers and representatives from medical professional organizations and donor agencies. This meeting reviewed the project and reached consensus and obtained commitment from the federal and the state governments to support the midwifery training and health communication interventions.

## Formative Research

Subsequent to this meeting, a private Nigerian research agency, Public Opinion Polls (POP) was contracted to conduct qualitative research in Oyo/Osun and Bauchi. Technical guidance in the design of the research instruments was given by MotherCare. On-site technical assistance in planning, implementing and analyzing the research and its results was conducted by MotherCare and USAID's Nigeria-based family planning project (Family Health Services—FHS) IEC Division managed by the Johns Hopkins University Population Communication Services.

The investigators conducted in-depth interviews and focus group discussions in both rural and urban locations of Bauchi and Oyo/Osun states. Participants were recruited from Fulani, Hausa and Yoruba communities and included pregnant women and those who recently had delivered, their husbands/partners, community leaders, traditional birth attendants, traditional healers, nurse midwives and obstetrician/gynecologists.

The study revealed not only knowledge, attitudes and behaviors but also the flow of information within the community and the family decision-making processes that govern the utilization of traditional or formal health services. Following are some of the results:

- Pregnancy-related food taboos effectively eliminate several accessible, essential sources of protein from a woman's diet. The effects of nausea, diminished appetite and the enforcement of taboos on food consumption are not, however, compensated for by a reduction in the woman's workload. Thus, many women are inadequately nourished and exhausted throughout their pregnancies. Husbands and in-laws collaborate in maintaining these traditions.
- Attendance at prenatal care clinics is not widespread. Transportation to these facilities and the cost of drugs and vitamins represent obstacles to clinic utilization for many of those who seek this care, especially among the rural (agricultural/nomadic) Fulani.
- The belief among many Fulani that pregnancy is a private affair and the concept of "shame" underpinning this belief prevent many rural Fulani women not only from attending prenatal clinics but also from seeking help when they suspect something may be wrong.
- Prenatal care is seen by some women and men as insurance against complications during delivery and ironically may create an overconfidence about the prospects for a healthy home delivery. Among the Yoruba, receiving prenatal care did not seem to lessen the likelihood that, in the event of complications during labor, traditional medicine would be eschewed in favor of formal health care.
- Misperceptions of the early warning signs of obstetrical complications were found to be a serious contributor to delays in seeking emergency care where available. Swelling of the face and hands, headaches, bleeding and premature rupture of the membranes are all considered normal.
- Transportation costs and logistics may preclude timely arrival at the hospital; once there, long waiting periods and lack of adequate personnel and equipment may preclude effective treatment. Nurses and doctors describe their irritation with this situation; community members protest their poor handling by health professionals, which

may in fact result from the frustration of trying to save women who arrive at the hospital too late or whose families cannot cover the costs of drugs and equipment that hospitals may require.

- Traditional healers, who use herbal treatments and biblical or Koranic verses in providing care, and birth attendants may refer women to the hospital only when their own methods are unsuccessful and usually too late for the formal medical network to be effective. Yoruba traditional healers who were interviewed did not see a conflict between traditional and Western medicine and believe that the two systems can coexist. In fact, among the Yoruba, first-time mothers are considered high risk and often sent right to the hospital at the onset of labor.
- Hospitals and clinics constitute an acknowledged important source of reliable information about pregnancy, delivery and infant care, despite the fact that hospital care is seen as inadequate. Respondents cited long waits, scarcity of drugs and equipment, and the hostile attitude of hospital personnel as reasons to avoid hospital delivery. Fulani from more remote villages felt that hospital personnel singled them out for particular ill-treatment and longer waiting periods because they are regarded as being "in the bush." Doctors' unwillingness to permit nurses to be trained to perform limited clinical procedures probably increases waiting time. That most hospital deliveries in some areas appear to be emergency deliveries undoubtedly contributes to the stressful atmosphere described by staff and patients.

## **Strategy Formulation and Development**

The research findings were reviewed and health communication strategies were designed with each state during a health communication strategy development workshop conducted by the FHS IEC Division. Participants included health and health communication representatives from the federal and state ministries of health and a variety of mass media and community-based non-governmental organizations of Oyo/Osun and Bauchi states. The two-week workshop took participants through the theoretical concepts of health communications as it applies to behavior change, the use of formative research results to formulate strategies, the practical applications of developing, pretesting and finalizing messages and media, and the actual design of a strategy, budget and work plan for implementation.

The key topics to be addressed by the health communication component for which audiences, objectives, activities and messages and media were identified include the following:

- identifying beneficial and harmful traditional practices which make up self-care activities, reinforcing or redirecting them, respectively;
- timely recognition and timely decision-making regarding danger signs and complications during pregnancy, delivery and the postpartum period—what to do, where to go, when to go;
- the importance of delivering with a trained midwife;
- the importance of colostrum and exclusive, immediate breastfeeding;
- the importance of good client-provider relationships; and
- the importance of blood donation—the advantages, the process and the benefits.

Key audiences which will be involved in the health communication component include the pregnant woman and her family, community and traditional health care providers, and midwives, community health workers and non-governmental organizations.

Activities will include (1) interpersonal skills training for midwives, TBAs and community health workers; (2) a monthly "MotherCare Activities Day" at the upgraded midwifery clinics; and (3) a mix of radio, TV, print and traditional media to promote danger signs and timely use of services.

## **Implementation and Monitoring**

The health communication component is being implemented by Bauchi and Oyo/Osun states with funding and technical assistance from the FHS IEC Division. Implementation is not expected to begin until late 1993.

To measure the project's impact on affecting the above topics, a baseline and final survey will be conducted. Clinic data will complement the surveys by providing more behavioral information regarding utilization of services.

Clinic exit interviews will also be conducted to determine how interpersonal skills and counseling are being put to use by midwives. A preliminary baseline of 50 women in prenatal and postnatal periods yielded some interesting patterns:

- Nearly 90 percent of postnatal care clients were given some sort of medication, but only 30 percent were told what the medication was for or how to take it.
- In prenatal care, 72 percent had waited over an hour to be seen; 26 percent of the clients were asked if they had any questions; three percent were told about their blood pressure after it was taken. However, 90 percent were given (over the duration of their pregnancy) tetanus injections; 70 percent were told about good types of food to eat during pregnancy; but only 34 percent were told about immediate and exclusive breastfeeding.

## ***Findings and Future Directions***

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Since the actual health communication campaign has not yet been implemented, data are unavailable regarding impact on knowledge, attitudes and practices. There are, however, some lessons learned about the process of affecting behavior through a health communication intervention:

- Counseling is a life-saving skill and should be at the foundation of any health communication component.
- Despite contracting a skilled local firm to conduct the research, substantial technical assistance was given to supplement POP's skills and experience.
- Collaboration with existing local child survival or family planning projects that have a strong health communication component can greatly facilitate implementation and monitoring of maternal health health communication components.

In the future, the Nigerian federal and state health authorities will strive for continued focus on strengthening the project states' capabilities to provide maternal health services to its citizens as well as to provide a model program to other states in their respective health zones. Training will continue, as will health communication campaigns meant to generate demand for services. But management and supervision and fiscal policy issues will be addressed in order to institutionalize interventions. At the same time, maternal health packages of proven value (i.e., partograph training; prenatal risk assessment) will be offered to other states which have politically and fiscally committed themselves to improving maternal health care services. Concurrently, the integration of micronutrient and STD components into on-going services will be explored in areas where existing infrastructures and policies exist to provide such services.

***N.B. At the time of this report, no sample health communication materials were available for inclusion in this profile.***

## ***Bibliography: Nigeria***

1. For further information and copies of the original materials produced under the health communication component of this project, please contact:

**USAID/Lagos Family Health Services Project**

Global House  
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**The Johns Hopkins University Center for Communication  
Programs/Population Communication Services**

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2. For copies of the following reports, please address inquiries to:

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Arlington, Virginia, 22209 USA  
*Attn: MotherCare Publications*

(Please request the general MotherCare bibliography for a complete listing of all special reports, working papers and trip reports)

3. For further information on social marketing and health communications, please contact:

**The Manoff Group**

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Washington, DC 20009 USA  
(Telephone: 202-265-7469; Fax: 202-745-1961)  
*Attn: Marcia Griffiths, President*

## ***Special Reports***

MotherCare Final Report

Nigeria Final Report

*Interpersonal Communication and Counseling Curriculum for Midwives*

August, 1993  
Nigeria

## **Working Papers**

### *Behavioral Determinants of Maternal Health Care Choices in Developing Countries*

Working Paper 2  
November, 1990  
Mona Moore

### *Interventions to Improve Maternal and Neonatal Health and Nutrition*

Working Paper 4  
December, 1990  
Niki George

### *Communicating Safe Motherhood: Using Communication to Improve Maternal Health in the Developing World*

Working Paper 14  
November, 1991  
Marcia Griffiths  
Mona Moore  
Michael Favin

### *Nigeria Maternal Health Project Qualitative Research: Literature Review*

Working Paper 17A  
August 1993  
Public Opinion Polls, Ltd.; Lagos, Nigeria

### *Nigeria Maternal Health Project Qualitative Research*

Working Paper 17B  
August 1993  
Public Opinion Polls, Ltd.; Lagos, Nigeria

## **Trip Reports**

April 22 – May 10, 1991 (initial assessments)

Colleen Conroy  
Peg Marshall

February 14 – March 7, 1992 (project proposal development)

Colleen Conroy

June 21 – July 3, 1992 (policy leaders' strategy development workshop)

Kim Winnard

# *Philippines*

## *Supporting Midwifery Case Management*

### *Background*

The official maternal mortality ratio in the Philippines is estimated at 80/100,000 live births. However, this ratio is thought to be significantly underestimated, as many deaths among pregnant women are reported as deaths from other causes (conditions or diseases concurrent with pregnancy). Also, because these statistics are facility-based, they do not necessarily reflect mortality in rural areas where 70 percent of the 62 million Filipinos live. In some rural areas (and in poor urban communities), the maternal mortality ratio is thought to be twice as high as the national figure. The leading causes of reported maternal deaths include hemorrhage (32 percent of total reported maternal deaths in 1984) and hypertension (31 percent of all maternal deaths reported in 1988).

Factors influencing unacceptable levels of maternal and infant mortality and morbidity identified by the Department of Health include:

- uneven distribution of health staffing and equipment;
- uneven and inadequate knowledge of basic obstetrical case management by some of the birth attendants in the underserved areas;
- low levels of contraceptive prevalence;
- poor logistical support for obstetrical emergencies;
- inadequate facilities in Rural Health Units (RHU) and hospitals for managing high-risk cases; and
- inadequate monitoring tools and mechanisms for reporting care rendered to mothers and children.

### *The Program*

MotherCare, with less than one year left in its program period, supported the effort of the Department of Health's Maternal and Child Health Services to strengthen the quality of maternal care services and promote the integration of maternal care with family planning services. The following activities were undertaken:

- developing protocols of care to guide midwifery practice, particularly as it is related to risk assessment and response to obstetrical emergencies;
- testing protocols and developing a training course to train midwives in the use of the protocols, including client counseling skills; and

- conducting a training of trainers course for the use of protocols in risk assessment and the care of obstetrical emergencies.

Health communication objectives and activities focused on supporting midwives' case management, as well as their interaction with clients and hilots (traditional birth attendants).

## **Formative Research**

One of the first activities undertaken was a review and synthesis of existing Department of Health quantitative and qualitative research to help form the basis for health communication messages and materials for midwives, hilots and pregnant women. This literature review covered existing studies where interviews with hilots, midwives, pregnant women, and their husbands, as well as observations of counseling sessions between midwives and clients were reported in order to:

- identify key factors that motivate, enable and deter pregnant women in seeking prenatal to postpartum care, and midwives and hilots in rendering it; and
- assess knowledge, attitudes and behaviors of pregnant women toward danger signs and complications during the prenatal to postpartum period and where and when they first seek help.

### **Some of the most significant findings in the review are:**

- For many women, pre- and postnatal clinical care is a matter of awareness but not practice. Women generally do not seek prenatal care until the last trimester of pregnancy. Many women believe prenatal care is only for sick women or women who have experienced complications during previous pregnancies and deliveries.
- Pregnant women reporting poor personal treatment by medical personnel are less willing to seek care.
- While women acknowledge the more advanced clinical care available at health facilities, many prefer the services of hilots who live nearby and provide comprehensive care during delivery and postpartum.
- Most women interviewed display limited knowledge of the complications of pregnancy. Most consider sickness, discomfort, backache, abdominal pain, coughing and fainting to be danger signs. Many think that certain complications are caused by their not attending prenatal care. Most do not know the difference between edema and high blood pressure, and few are aware of the need for services such as blood pressure-taking, urine tests and tetanus toxoid injections during pregnancy.
- Many women prefer to give birth at home with their family in attendance. Many are reluctant to deliver in a clinic where they will be ashamed of being exposed and of screaming.
- Government-trained hilots display better knowledge of safer delivery practices than untrained hilots. However, even among trained hilots there are significant knowledge gaps (only 42 percent use a sterile tie or clamp to cut an umbilical cord). Knowledge of complications among all hilots is low.

- Midwives display greater knowledge of complications but, in general, did not display a systematic approach to treating obstetrical emergencies or to making proper referrals.
- Midwives tend to be didactic and prescriptive in their interactions with clients as opposed to interactive, an approach better received by clients. Furthermore, the messages they impart to their clients tend to be too general to be effective.

This research, in addition to data generated by a Comprehensive Program Review conducted by the Department of Health and WHO in 1990, underscored the need to increase pregnant women's understanding of the benefits of prenatal care, train hilots in safer delivery practices, enhance midwives' case-management and counseling techniques and promote greater awareness of the need for appropriate referral and cooperation among service providers.

MotherCare technical assistance initially focused on developing standards of practice with the Department of Health. The result of this effort had been the development of a draft technical manual for midwives which included updated medical technology and flow charts on the management of prenatal and postpartum danger signs and complications during delivery. Specific tasks undertaken to develop a supportive health communication strategy included the following:

- Orient the Department of Health to the role of social marketing and health communications in the delivery of traditional and formal maternal health care.
- Assess maternal health care delivery as it applies to counseling and health communication materials, including a review of health communication materials developed and resources available to research, develop, design, pretest, produce, distribute and train in the use of messages and health communication media materials.
- Develop general approaches and strategies promoting maternal health awareness and behavior change among service providers, clients and their respective support groups, to include categories of audiences, messages and media.
- Prioritize objectives, audiences, messages, media and geographical focus, and create a draft workplan, budget and schedule to implement activities.

## **Strategy Formulation and Development**

Following are the objectives that guided the project's short-term health communication implementation plan:

- Increase midwives' understanding of the general distinction between the risk factors and danger signs of pregnancy, the recognition of both, and the case management of and counseling for life-threatening prenatal and postpartum danger signs and delivery complications.
- Improve the interpersonal communication skills of midwives toward clients during prenatal and postpartum interaction.
- Increase hilots' understanding and recognition of delivery complications (and, possibly, danger signs of pregnancy) and the importance of proper management and referral.

- Increase awareness among pregnant women of the importance of prenatal care and its utilization.

## Implementation and Monitoring

With the technical assistance of a local health communication consultant, the Department of Health developed and pretested the following health communication print materials for midwives, hilots and pregnant women:

- midwives' flipchart (using Midwifery Manual case management flow charts) on recognizing, managing and counseling for antepartum and postpartum danger signs (includes urgency of considering family planning) and complications of delivery;
- midwives' carry-all bags containing messages on good counseling skills;
- hilots' reminder card for recognizing and referring delivery complications and danger signs; a comic book to promote better relations between midwives and hilots;
- pregnant women's reminder card (in the shape of a fan) for recognizing and acting upon danger signs during pregnancy; and
- pregnant women's comic book on prenatal care.

The print materials for pregnant women included an adapted version of the following "ten commandments" for prenatal and delivery care:

**WHEN YOU KNOW (or when you show), YOU SHOULD GO.** Prenatal care helps you and your baby have a healthier pregnancy. Make your first visit to the nearest health center as soon as you realize you are pregnant (when you miss one or two periods).

**FEEL WELL? STAY WELL!** Have a prenatal check-up at your nearest health center at least every two months or when asked to come in for a check-up, even if you feel well, so you and your baby can stay well.

**FINAL CHECK, WHAT TO EXPECT.** During your last month of pregnancy, be sure to have a prenatal check-up to prepare for what you need to know (including the position of your baby) and do during delivery.

**IF YOU'RE SICK, MAKE IT QUICK.** Visit your nearest doctor or midwife for a prenatal check-up when you feel sick or whenever you experience the following "danger signs":

*your face or hands swell up;*

*you are bleeding from the vagina;*

*you feel more weak than usual and look more pale than usual;*

*you have nausea or vomiting with a headache more painful than usual;*

*you have sharp belly cramps.*

**RETURN AND LEARN.** Return to your nearest health center for a prenatal check-up whenever you are asked by a health provider to come for a check-up.

**EAT FOR "TWO," YOUR BABY AND YOU.** Eat and drink more good food and liquid than you are used to eating for your own health and your baby's growth. Make sure you drink more water, eat more available dark leafy vegetables, meats, starchy foods and fruits.

**REST IS BEST.** Your body and your baby needs more rest during your pregnancy, at least one hour during the middle of the day and from sunset to sunrise.

**SHARE THE LOAD.** Your body needs to save its strength for growing and delivering the baby. Let someone else carry heavy loads for you; let someone else do the more strenuous backbending farm work for you.

**FIND A HELPER TO DELIVER.** Identify a *government-certified, trained* health worker (doctor, midwife, nurse, traditional birth attendant) that you can depend upon to see you through your pregnancy and help you at the time of your delivery.

**WHEN THE TIME COMES, BE READY TO GO.** Sometimes, delivery is difficult and women need additional emergency help. Make sure you have already planned a means of transport to go to a hospital in case of an emergency and money to pay for the transport and hospital.

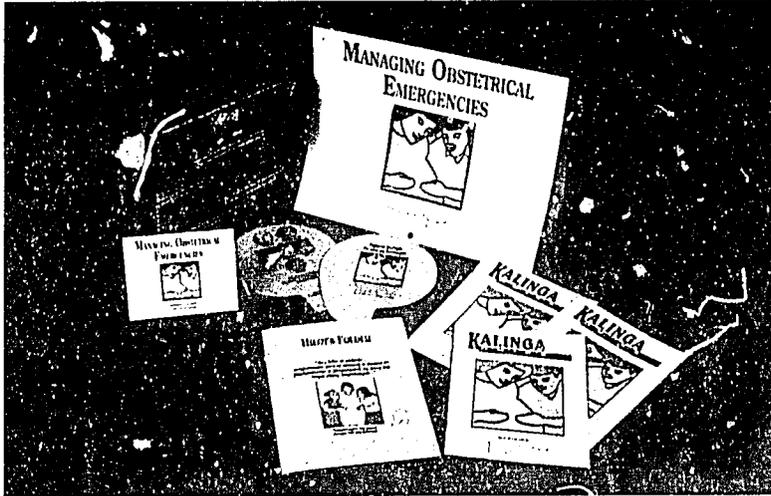
## ***Findings and Future Directions***

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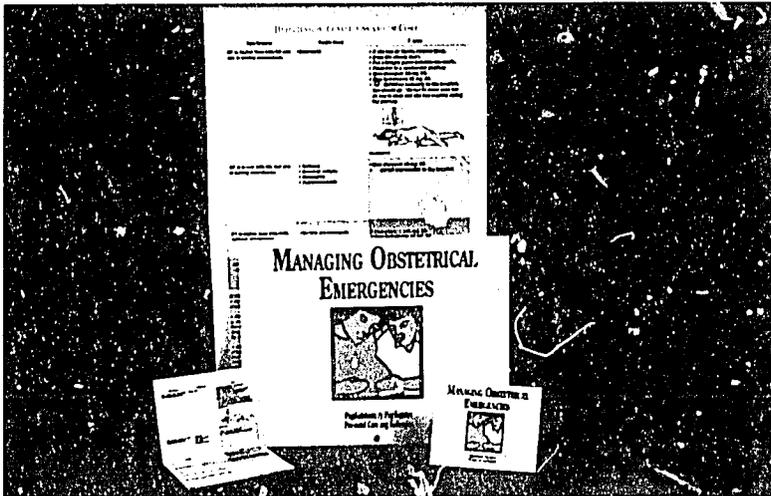
The short duration of MotherCare support did not preclude the initiation of specific interventions to strengthen midwifery skills and case management and to increase awareness of their clients. But time has not allowed most activities to be fully implemented, monitored and evaluated. However, a maternal health-specific interpersonal communication (IPC) skills training module (using the existing Department of Health Family Planning IPC training module and the MotherCare/Nigeria Maternal Health IPC training module) will be developed to strengthen midwifery counseling skills and act as a venue for distributing health communication print materials.

The Philippines has just begun to develop an integrated approach to design and implement maternal health programs. The next steps will be to continue these efforts in northern Mindanao (Region X), the designated pilot area where research and health communication pretesting activities have already begun.

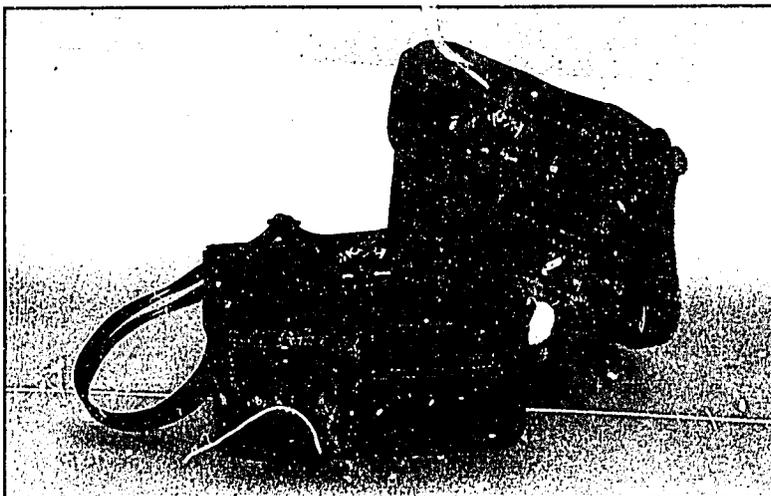
## Philippines Health Communication Materials



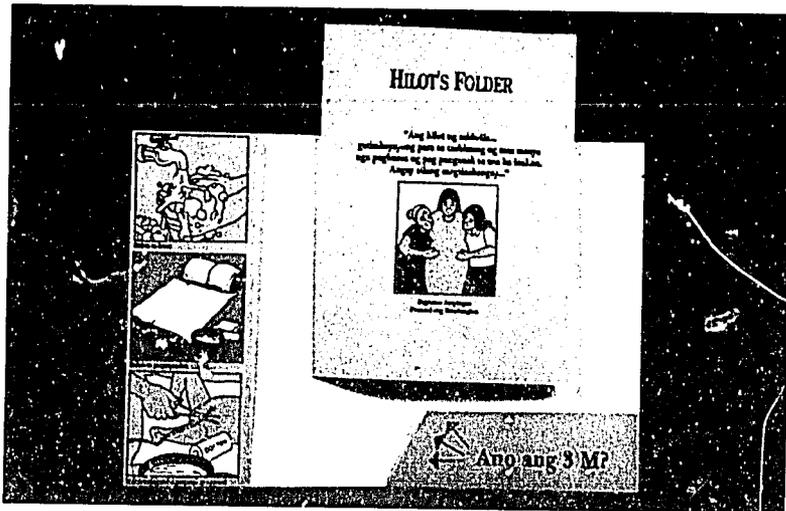
- A. Midwife Flipchart and Bag, TBA Folder and Motivational Take-home Print Materials for Pregnant Women



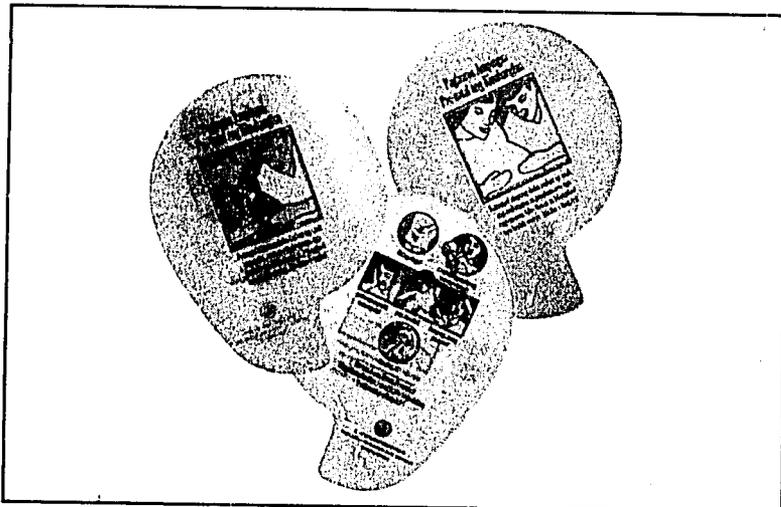
- B. Flipchart for Midwives to Use as a Training Guide and When Managing Obstetrical Emergencies (as a Supplement to the Midwifery Training Manual)



- C. Midwife Carry-all Bag Promoting Good Counseling Skills



D. Hilot (traditional birth attendant) Folder Listing Safer/Cleaner Home Delivery Techniques and Collaboration with Midwives



E. Fan for Pregnant Women Promoting Routine Prenatal Care and Recognition of Danger Signs



F. Comic Book for Pregnant Women Promoting Prenatal Care Attendance

## **Bibliography: Philippines**

1. For further information and copies of the original materials produced under the health communication component of this project, please contact:

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(Please request the general MotherCare bibliography for a complete listing of all special reports, working papers and trip reports)

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## **Special Reports**

MotherCare Final Report

The Philippines Final Report

## **Working Papers**

*Behavioral Determinants of Maternal Health Care Choices in Developing Countries*

Working Paper 2  
November, 1990  
Mona Moore

*Interventions to Improve Maternal and Neonatal Health and Nutrition*

Working Paper 4  
December, 1990  
Niki George

*Communicating Safe Motherhood: Using Communication to Improve Maternal Health  
in the Developing World*

Working Paper 14

November, 1991

Marcia Griffiths

Mona Moore

Michael Favin

**Trip Reports**

The Philippines Trip Report (initial assessments)

June 8 – 19, 1992

Colleen Conroy

The Philippines Trip Report (design of the health communication component)

March 8 – 20, 1993

Kim Winnard

# *Part IV*

## *Back to Basics*

***Research, program development and implementation have revealed several universal issues regarding the seeking and providing of maternal health care that are important to the person crafting the health communication message and media:***

- **Pregnancy is considered neither an affliction nor a period of special care;** seeking care is rarely routine and focuses on emergencies.
- **Emergency care is sought only when signs of pending danger or actual maladies are recognized** and then if they are considered serious enough for seeking help. Edema, for instance, is considered a “normal” experience for most pregnant women; swollen hands and face are treated with equal ambivalence as swollen ankles and legs.
- **Danger signs and complications are not known by their medical terms** and must be described precisely using local words rather than more abstract medical terms. For example, “edema” should be more explicitly described by highlighting swelling of hands or face. “Bleeding” should always be accompanied by a description of the color (e.g., dark or bright), quantity (e.g., soaked through three burlap sheets) and time period (i.e., during pregnancy, during labor, during delivery, after delivery). Even the “onset” of labor may have a very different description based on the severity, type and location of pain than do labor pains at the “onset” of delivery.
- **Recognition by a pregnant woman and/or her supporters and enablers** of danger signs during pregnancy and complications during delivery (for instance, a woman in labor longer than 12 hours needs help), making timely decisions to seek help (after 12 hours), and actually seeking help in a timely fashion (immediately) are key client-focused determinants in reducing maternal mortality and morbidity. However, the focus of health communications often must be on supporters of the woman in addition to the woman herself; it is difficult to recognize and make decisions for oneself in the middle of a complication.
- **Recognition by a health care provider** of danger signs during pregnancy and complications during delivery, providing timely care and making timely decisions to refer are key provider-focussed determinants in reducing maternal mortality and morbidity. Whether TBA or midwife, appropriate case management, adequate supplies and drugs and the timely and proper use of referral to a higher level of care where maternal and obstetrical emergencies can be handled is crucial for the survival of the woman.

- **Alternative delivery sites to the home** should offer at least the values and feelings derived from home delivery. Whether their proximity is near (community birthing huts) or far (hospital), birthing sites should respect the client's desire and need for family members to be present or nearby, privacy, and a setting that is comfortable and safe in the perspective of the client.
- **Coverage** (for instance, taking iron folate tablets) **and compliance** (for instance, taking iron folate tablets regularly and properly) are two separate issues and must be treated as such in any social marketing and health communication program.
- **STD counseling** of clients should include assisting them to identify ways of negotiating supportive behavior change of their partners. For women, this also means taking realistic measures to prevent reinfection if partners cannot be approached or do not comply.
- **Changing the behavior of the client toward the use of services** is usually dependent on a behavior change of the service provider regarding the provision of less threatening, more culturally appropriate services.

*What has also emerged from the MotherCare experience is a foundation of objectives, audiences and messages for establishing a maternal health health communication component. The following outline of this foundation, however, can be used only after extensive, up-to-date, formative research and substantial pretesting have been conducted to address the needs and perspectives of clients and providers involved:*

## Objectives

### ▶ Household/Community:

1. Promote improved maternal self-care (e.g., nutrition, workload).
2. Improve early recognition of and response to danger signs during pregnancy, labor and delivery, postpartum and neonatal periods.
3. Inform people about importance of complying with recommendations to utilize services/products.
4. Promote immediate and exclusive breastfeeding of newborns, as well as warming, hygiene and cord care.

## Interaction Between Community and Health Care Network:

1. Prepare community to react quickly to reduce care-seeking delays.
2. Increase provision and then demand and utilization of products/services.
3. Strengthen counseling skills of service providers and midwives.
4. Strengthen appreciation by health care network of beneficial, non-harmful practices of the community.
5. Improve formal health linkages and outreach with communities (e.g., placement of obstetrical emergency personnel, equipment and supplies in primary health care settings) and traditional health networks.

## Health Care Network

1. Motivate use of safer birthing techniques and materials.
2. Recognize and comply with timely referral of pregnant women with danger signs, complications during delivery and danger signs of newborn;
3. Decrease harmful practices.
4. Strengthen follow-up counseling for postpartum complications.
5. Strengthen management and supervision, case management and infrastructure of services to comply with needs of client.

## Audiences

### Household/Community

1. Pregnant women
2. Their husbands or partners
3. Their mothers-in-law/elder sisters
4. Their political, traditional and religious leaders

## Health Care Network

1. TBAs and traditional healers
2. Community-based health care providers
3. Clinic-based health care providers (midwives, nurses)
4. Ob/Gyns
5. Medical (administrative) officers

## Behavior Content for General Messages

### Household/Community

#### 1. Self-Care for Maternal Health

##### *Antepartum (all pregnant women):*

- Increase quantity and quality of nutritious foods.
- Reduce heavy work load and rest more often.
- Consume iron folate tablets to prevent anemia.
- Community groups to consider emergency funds/blood donations/transport system for complicated deliveries.

##### *Intrapartum (pregnant women who stay at home):*

- Ensure safer delivery by requesting trained TBA (if there is one) and using “kit” (i.e., razor blade, soap, towel, sheets, string, matches) for safer delivery.
- Ensure woman in labor consumes as much water as she wants and urinates frequently.
- Recognize and refer complications, especially retained placenta, obstructed or prolonged labor; excessive bleeding; malposition.
- Immediately put newborn to the breast and begin exclusive breastfeeding; care properly for cord; ensure care and warmth of newborn.

##### *Postpartum (all new mothers):*

- Nutritious food and rest for mother.
- Exclusive breastfeeding of newborn for four to six months.
- Iron folate tablet consumption.
- Family planning method/counseling no later than 6 weeks after delivery.
- Care of the newborn (e.g., ARI, diarrhea).

## **2. Use of Prenatal and Delivery Services**

***Importance of prenatal care and attendance: what types of prenatal care and delivery services are offered and why they are important to use:***

- Attend routinely even when you are feeling healthy, at least for the following specific, recognizable events or activities:
  - to verify pregnancy and have first check-up (including STDs and nutrition screening);***
  - to receive any needed tetanus shots and iron folate tablets to take daily during part or all of pregnancy;***
  - to receive final check-up during the last month of pregnancy (if pregnant woman is told when that is) to determine the growth and position of the baby.***
- Know where to go and when a midwife/trained health provider will be there.
- Know why services are convenient and attractive to visit and utilize.

***Importance of complying with instructions of health provider (depends partly on counseling ability) to come back for care or to seek a “higher level” of care:***

- Attend prenatal care when asked to come back, and comply with visiting a doctor and/or a hospital, even if feeling healthy.

***Self-recognition by attenders and non-attenders of prenatal care: importance of seeking care (self-initiative):***

- Attend when feeling sick or feeling any of these conditions (i.e., danger signs of pregnancy):
  - swelling of face and/or hands;***
  - vaginal bleeding of any amount or color;***
  - dizziness or convulsions;***
  - fever and/or severe headaches; and***
  - malpresentation.***
- Attend if have history of poor pregnancy outcomes (e.g., stillbirth, Caesarean section or any instrumental delivery).

***Importance of giving birth at the appropriate place and with the appropriate attendant (depends partly on whether pregnant woman has been counseled on her own risk factors and on where to deliver, and if quality care exists at delivery site):***

- Select site best suited to the woman’s needs:
  - community delivery site (home or TBA);***
  - primary health care (community delivery house, if any);***
  - secondary/tertiary care (clinics, hospitals attended by midwives/doctors).***

- “Take the first step” to the place where a pregnant woman has decided to deliver, when:
  - onset of labor contractions (how defined or noticeable?);*
  - water breaks;*
  - bleeding starts;*
  - TBA tells woman to prepare.*
- Why it is important to follow the advice of the midwife or trained TBA regarding where to deliver.
- Why attended and institutional deliveries can be a safer place to deliver than alone at home.

***Importance of recognition of labor and delivery complications (for pregnant women, but more so for TBAs and, as appropriate, husbands/mothers-in-law). Take action when the following occurs:***

- *prolonged labor*
- *massive hemorrhaging*
- *prolapse*
- *convulsions*
- *malposition*

## ➡ Health Care Network

- ☒ Changes in behavior within the medical health care network should be stimulated and driven by the needs of the client and the community; health care, after all, is a service.
- ☒ Clinical and especially interpersonal communication and counseling training for TBAs, midwives and other health care workers is a key channel for changing service provider behavior.
- ☒ Concomitant with changes in human resources, the following activities should be undertaken:
  - Service site improvements (facility, supplies, equipment);
  - Transport improvements (outreach);
  - Pricing improvements (incentives);
  - Improvements in linkages between TBAs and midwives, between referral sites, and between health services;
  - Policy improvements;
  - Management and supervision improvements;
  - Specific health communication campaigns promoting the quality of service rendered by the service provider.

## Reminders About Changing Behavior

***In closing, there are six major tenets to keep in mind when developing maternal health programs that have, as one objective, behavior change:***

- ***Behavior cannot be changed if it is not first understood.***
- ***Realistic behavior change takes time and resources.*** It requires an integrated approach, where multiple interventions converge on a common goal and outcome. Therefore,

*When referring to interventions that affect behavior change, do not just stop with health communications. Continue with affecting policies, training, and service delivery (equipment and supplies, management and supervision, monitoring and evaluation).*

*Use formative research to design those health interventions, as well as health communications.*
- ***Behavior change is everyone's responsibility.*** Programs should address the perspective and needs of the client while sharing the responsibility of behavior change with her family, community, and especially, her service providers.
- ***Strengthen distribution of products and provision of services*** and evaluate their utility before complementing them with a major health communication campaign promoting those services or products.
- ***Negotiate realistic behavior change*** and come to an agreement between the client and the provider as a final step in any interaction.
- ***Maintain vigorous qualitative and quantitative monitoring*** of activities; social marketing and health communications are dynamic processes.