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, MotherCare/The Manoff Group
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

Indonesia Trip Report Number

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Executive Summary

Mona Moore, Maternal Health/Social Marketing Consultant to the Manoff Group, provided technical assistance to two MotherCare funded projects in Indonesia, "Improved Iron Folate Distribution to Alleviate Maternal Anemia in Indramayu, West Java" and "A Pilot Study of a Perinatal Regionalization Network" in Tanjungsari, during a three week visit 9 - 31 January 1991. For both projects, site visits took place, basic principles and steps of social marketing were discussed with project staff, and social marketing workplans and budgets were developed.

Indramayu

Project staff of the Indramayu project worked with the consultant to revise and expand existing research instruments for the formative research to investigate factors influencing compliance with iron supplementation among pregnant women in the project area.
The qualitative research plan was reviewed. Proposed qualitative research activities were modified, adding a concept testing step to determine acceptability of iron tablets to the depth interview for pregnant women. A protocol and instruments for the formative research were drafted. A brief interviewer training was conducted, covering the main points of qualitative research techniques.

The overall Indramayu operations research study design was discussed, and it was returned to the design proposed initially. This design requires completion of the qualitative research by April 1991, prior to strategy formulation and implementation of the proposed iron tablet distribution intervention. Therefore, the social marketing workplan was accelerated, reflecting the project's rapid information needs.

Project staff are in the process of translating and pretesting research instruments developed during this TA visit. Additional technical assistance is tentatively planned for April 1991, to assist with analysis of the research results, preparation of the research report and formulation of strategy and interventions. Recommendations include more intensive technical assistance than originally anticipated during the period from April - October 1991, when the communications materials are scheduled to be completed.

Tanjungsari

The consultant made a brief two day visit to Bandung to discuss the proposed social marketing component with staff. Several key staff members were not available to participate in planning and discussions. Site visits included the health center and village
health posts serving the Tanjungsari project area, and the home of a survey interviewer. Discussions with staff focussed on the need to more clearly define the project's communications objectives, qualitative research needs and staff research capabilities. A preliminary social marketing workplan and budget were drafted.

After discussing the social marketing process, staff have tentatively agreed to the consultant's recommendation that full-time local technical assistance be sought for the implementation of the formative research and for communication materials design and production. This local technical assistance is in addition to that available through MotherCare/ The Manoff Group.

Additional recommendations include the need for further discussions among the principal investigator, MotherCare and Manoff staff and the USAID Mission in Jakarta, to decide on a realistic scope and content for the social marketing component of this project. This should be followed by a visit a social marketing consultant, when all key project staff are present, to finalize the workplan and define budget and technical assistance needs.
I. Purpose of Consultancy

The original scope of work for this technical assistance visit to the two MotherCare-funded projects in Indonesia, "Improved Iron Folate Distribution to Alleviate Maternal Anemia in Indramayu, West Java" and "A Pilot Study of a Perinatal Regionalization Network" in Tanjungsari focused primarily on:

- site visits and orientation to both projects
- review of basic principles and steps in social marketing with project staff,
- draft and review of social marketing workplan and budget, and
- review with staff draft question guides for depth interviews (Indramayu project only).

To meet the needs of the Indramayu project staff, and to assure timely availability of qualitative research results, several additional objectives were added for this visit. These included:

- drafting a detailed qualitative research plan,
- revision and expansion of existing question guides for pregnant women, bidans, dukun bayi, elder women and husbands regarding behavioral and attitudinal aspects related to iron compliance
- discussion and subsequent addition of a concept testing step to the in depth interviews for pregnant women. This step requires that women actually take the iron tablets. A draft question guide was developed, to be used in conjunction with distribution of iron tablets to small sample of women at time of depth interview.
- brief interviewer training covering the main points of qualitative research techniques and suggestions for further practice in the field setting
- review of available health education materials related to pregnancy and/or iron in pregnancy

Five additional working days were added to allow completion of the objectives listed above.
II. Indramayu Project

A. Background

The 21-month MotherCare-funded project, Improved Iron Folate Distribution to Alleviate Maternal Anemia is nested within a larger ongoing project of the Center for Child Survival/University of Indonesia, The Indramayu Health and Family Planning Prospective Study. This larger study, currently funded by the National Family Planning Coordinating Board of Indonesia and USAID, began in January 1989. The project, with technical assistance from the Population Council, developed and employs a community-based sample registration system (SRS) in two adjacent subdistricts, Gabus Wetan and Slyieg, in Indramayu, West Java. In addition to providing basic quantitative data on maternal and child morbidity and mortality in the project area, the SRS and related activities are intended to serve as a source of information from which appropriate intervention strategies to improve maternal and child health can be developed and implemented.

As part of the larger maternal and child health status data collection exercise, several instruments have been designed and are currently in use. Data collection occurs in 90 day cycles or "rounds". The project is currently collecting the fifth round of data. Pregnant women, among the 10,000 study households, are identified in the process of collecting information using the Household Record Book (Module A) and Maternal and Child Record Book (Module C).

The recently pretested and revised final version of the Pregnancy Module (Module D), funded by MotherCare, will be administered to these pregnant women, yielding quantitative data on maternal health status (anthropometry, pregnancy related morbidity and mortality, hemoglobin levels) and practice (prenatal care use, self care, use of modern and traditional medications during pregnancy, including iron supplements, nutrition, and smoking and alcohol consumption). The draft version of Module D which was available during this visit is attached as Appendix D. Also as part of the larger study, a cross sectional KAP study of 500 women, funded by BKKBN, is in the design process and will be conducted during the first quarter of 1991.

To complement the Pregnancy Module, the project plans to collect qualitative information on many aspects of pregnancy, including prenatal nutrition, maternal health seeking behavior and lifestyle (traditional ceremonies and remedies and sexual activity), and factors influencing iron compliance among pregnant women.

The MotherCare-sponsored operations research project, which The Population Council helped project staff to design, has as its
primary objective to test the effectiveness of two interventions: 1) alternative distribution of iron tablets to pregnant women, and 2) use of improved iron/anemia health education materials developed through a social marketing approach. Although the entire Indramayu project presents many possibilities for formative research and/or application of a social marketing approach, this technical assistance visit focussed on working with project staff specifically on the formative research required by the OR project: to investigate perceptions in the study area of anemia and factors influencing compliance with iron supplementation during pregnancy.

It is expected that information generated by the formative research will support both of the proposed interventions to alleviate maternal anemia: 1) to guide the design of the as yet unspecified alternative system for distribution of iron tablets to pregnant women in the project area, and 2) to provide a basis for development of appropriate communications materials.

B. Trip Activities

Following is a brief description of activities related to each item in the scope of work.

Review of Study Design

During this visit, as a result of consultation between local project staff, Population Council, MotherCare and USAID, the overall study design was modified slightly to more closely resemble the original plan and time frame:

First six months (October 1990 - March 1991): Design instruments and implement qualitative research.

Second six months (April - September 1991): Begin distribution of iron in both study areas and design and produce IEC materials.

Third six months (October 1991 - September 1992): Add IEC component in both study areas.

Last three months (April - June 1992): Wrap up and evaluation.

Discussions with project staff indicate that the exact mechanism of alternative distribution of iron tablets to pregnant women in the study area has not been chosen. The project proposal lists several possible distribution systems: 1) house-to-house distribution of tablets to pregnant women by TBAs, kader or other acceptable person, or 2) use of the home of any of the above persons as a depot for iron tablets, requiring women to visit the
home to receive tablets. The chosen alternative will be compared to the existing health center/village health post distribution system.

Staff will design the alternative distribution system based in part on acceptability of the various mechanisms documented by the formative research now in progress. As iron distribution is scheduled to begin in April 1991, the formative research results must be available within the next several months.

Produce Detailed Social Marketing Workplan and Budget

In consultation with project staff and Richard Pollard of the Manoff Group, a social marketing workplan and budget was drafted, reviewed and finalized. These documents are included in Appendix B. Specific steps involved in a social marketing approach to communications materials development were reviewed with project staff in Jakarta and in the field.

Review and Revision of Draft Qualitative Research Instruments

Project staff had prepared draft versions of the research instruments required to investigate factors influencing iron compliance among pregnant women in the project area. These draft instruments were reviewed, revised and expanded. They are: in-depth interview guides for pregnant women, bidans (midwives), dukun bayi (TBAs), elder women influentials, and husbands. (See Appendix C).

Special attention was directed at developing the sections of the question guide about sources of information, media exposure and preference. As project staff will rely on qualitative research results to guide the design of the alternative iron tablet delivery system, instruments were reviewed to assure that adequate information of this type would be generated.

Produce Qualitative Research Plan

The basic content and format of a qualitative research plan were reviewed with project staff. Project staff in Jakarta and Indramayu then identified preliminary global behavioral objectives and target groups for the communications program. That led to decisions on topic areas, methods, time frame and costs of the qualitative research. Decisions regarding the research plan included four major areas of investigation: service utilization, tablet supply, health system factors, and barriers to individual compliance. The detailed qualitative research plan is included as Appendix C. Main points are summarized below:

a. Methods and Sample Strategy

The project area includes approximately 10,000 households, and an estimated 1,200 pregnant women at most recent count. Information will be collected through use of depth interviews for pregnant
women, husbands, elder women, family members, midwives, TBAs, kader, and doctors in the study area. A total of 80 interviews will take place:

- 30 pregnant women in their second or third trimester of pregnancy, or within six months of delivery;
- six midwives and two doctors;
- ten kader and 12 TBAs;
- ten elder female family members and 10 husbands.

Number of interviews may be adjusted slightly if consistent patterns of information are recognizable prior to the planned number of interviews in each category.

b. Time frame

Draft instruments will be pretested during February 1991 and revisions completed by the end of February. Interviews will take place in March over a three-week period. Two female interviewers (Dra. Okarinda and Ir. Harahap) who are currently working with the larger MotherCare-funded quantitative study, will have primary responsibility for interviews of the pregnant women, elder women and dukub bayi. Two male interviewers (Dr. Riono and Drs. Budiono) will assist with the health staff interviews.

c. Research Objectives

1. Identify the behavioral, attitudinal or other factors which affect pregnant women's compliance with iron supplementation.

2. Identify sources of information/advice about pregnancy within the community and influentials who could influence compliance with iron supplementation.

3. Identify current channels or communication/media preferences for use in dissemination of iron-related IEC.

4. Identify current channels of distribution of iron tablets to pregnant women.

5. Determine the acceptability of several proposed alternative iron tablet delivery systems in the community, to both pregnant women and health providers.

6. Explore the level of awareness, use and attitudes toward iron in pregnancy of both women and providers of maternal health care (formal and non-formal).
7. Conduct concept testing on limited basis to get feedback from a small sample of pregnant women on iron tablet acceptability.

Project staff have considerable collective experience in implementation of quantitative research instruments, and have had some exposure to focused group discussions. However, as depth interview skills can more easily be built on to existing staff expertise in quantitative research techniques, and as limited time is available to reinforce the staff's FGD skills, depth interviews will be used to collect qualitative information in the project area.

MotherCare and Manoff Group staff, after reviewing the social marketing and qualitative research plans and instruments, suggested adding a small scale concept test (distribution of iron tablets and return visit to assess acceptability) to the depth interview protocol. This section of the guide was then drafted with project staff. The concept test phase is customarily a separate step in the social marketing process which follows and is guided by the results of the formative research.

**Interviewer Training**

This technical assistance visit was originally conceived as a planning and orientation visit, to discuss and plan with project staff the communications component. A return visit was planned prior to the actual implementation of the qualitative research. However, because of the accelerated time frame for the formative research agreed upon early in this visit, many of the tasks of the proposed second visit had to be accomplished during this first visit.

As a result, although five days were added, time available was not adequate to provide the in-depth training requested by project staff: review of qualitative research techniques (especially focus groups), methods for pretesting qualitative research instruments, and identifying formative research objectives and information needs. Jakarta-based project staff participated in a one day training session, in addition to the discussions with Indramayu project staff during the site visit. This session included a brief overview of qualitative methods, review and critique of the formative research instruments drafted for the Indramayu project, and suggestions for further practice in the field.

**Review of Available Prenatal Health Education Materials**

Health education materials for pregnant women have been developed in Indonesia by the MOH and UNICEF, among others. These materials were collected and reviewed, to determine whether utilization of existing, rather than development of project-specific, materials was a viable option for the Indramayu project. It appears, however, that the available materials were
not designed using a social marketing approach, and may not result in desired iron compliance behavior changes in the project area.

Site Visit

The project team and MotherCare consultant visited Sliyeg and Gabus Wetan subdistricts in Indramayu, to meet with local field coordinators, supervisors, and interviewers involved in the MotherCare portion of project activities. Discussions included description of project methodology and activities, and how to best integrate the social marketing approach into other ongoing project activities. The team briefly reviewed the steps in social marketing as well as the draft social marketing workplan and budget for the iron distribution and compliance study to be sure that these were realistic. The components of a qualitative research plan were also reviewed, and field staff contributed to the design and content of the draft qualitative research plan. Social marketing support materials (included as Appendix 5) were distributed and discussed.

Visits were made to the health center (PusKesMas) and several village health posts (posyandu). UNICEF iron/folate tablets were available for distribution to pregnant women at many posyandu and PusKesMas. Several sites were distributing locally produced iron tablets which do not contain folate, and are different in color, size and shape than the UNICEF tablets which have recently been procured by project staff for use in the project area.

Health center staff (bidans, kaders, and nurses) adhere to current MOH policy, recommending one 200 mg. iron tablet daily for pregnant women, beginning in the third trimester of pregnancy. Tablets are distributed in packets of thirty. This recommendation differs from the standard dosage in many other countries of three 200 mg. tablets per day throughout pregnancy.

Health education accompanying distribution of iron/folate to pregnant women varied according to practitioner interviewed. Prenatal education posters provided by the MOH were displayed at each location visited. A calendar produced by the national-level posyandu promotion project was also posted at each center visited, although the new 1991 version which contains a section for prenatal care had not been received.

C. Conclusions and Recommendations

Summary of Project Status

The MotherCare-funded activities, (a) design and implementation of the Pregnancy Module and b) operations research project to improve iron tablet distribution and compliance among pregnant women), are part of a larger ongoing project, the Indramayu Health and Family Planning Prospective Study. In spite of the
multiple responsibilities associated with all aspects of the study, project staff in Jakarta and Indramayu supported by MotherCare funds have accomplished almost all of the first quarter objectives for the MotherCare part of the project. These objectives center primarily on development of the research protocols and instruments for the Pregnancy Module (Module D). In addition, project staff have independently proceeded with development of draft instruments for the qualitative research for the iron compliance OR study. This is in part because on site MotherCare technical assistance was not available to the field during the first quarter of project activity.

Preliminary qualitative research protocols and draft instruments reflect the extensive critical thought which project staff have devoted to their development. There is considerable qualitative research/materials development experience and expertise within the staff. (A set of materials on breastfeeding, based on their own qualitative research in the Indramayu project area, has recently been completed). However, the research methods and materials development experience they have differs substantially from that required when using a social marketing approach to development of communications and other aspects of project intervention and activity. Project staff are extremely interested in acquiring additional expertise and experience in social marketing, qualitative research techniques and educational materials development using a behavior change orientation.

Project staff began translation of all research protocols and instruments developed during this TA visit during the first two weeks in February. In mid-February, the team returned to Indramayu to pretest the instruments and discuss the protocols, instruments and implementation issues with the field coordinators and field research assistant. If the schedule designed during this TA visit is maintained, interviews should be completed during March 1991. Analysis of results, preparation of the draft research report, strategy formulation and development of the communication plan for the IEC component should all take place during the month of April 1991.

In addition, the return to the original project design, agreed upon during this TA visit, introduces several important considerations: 1) distribution of iron tablets according to the current project schedule should begin in April 1991, and 2) IEC materials should be introduced by October 1991, if adequate time is to be allowed for these interventions to be implemented during the 21 month project time line. In order to maintain the current project time frame, and still utilize a social marketing approach, the qualitative research must be conducted rapidly, the alternative distribution mechanisms interventions selected, and communications materials developed, based on research results.
Recommendations

1. Additional technical assistance needs should be clarified. Project staff in Jakarta and Indramayu should now have had adequate time to discuss, pretest in the field and revise the research plan and instruments drafted during this TA visit. Dr. Budi Utomo should review results of field pretesting and research implementation with project staff as soon as possible, and clarify any urgent additional technical assistance needs. MotherCare/ The Manoff Group can provide assistance, as required, in two manners:

a) immediate assistance through fax/phone communication with Manoff staff/consultants in Washington to support the formative research now in progress, if any outstanding questions exist or if unanticipated problems arise. It is anticipated that the design and implementation of the concept testing phase may present some immediate challenges, as this was added toward the end of the TA visit, and not prepared as fully as other aspects of the research design. Richard Pollard of the Manoff Group is currently in Indonesia on another assignment, and is available to staff of the Indramayu project for clarification and assistance with research questions.

b) additional on-site technical assistance from a Manoff social marketing consultant, both to assist with further implementation of the research itself, and with analysis of results, report preparation and strategy planning. It was agreed during the TA visit that a three to four week TA visit would be required during April 1991. This can be pushed forward or otherwise adjusted, according to progress and needs in the field.

2. Manoff technical assistance for social marketing component should be reprogrammed. The MotherCare project has allotted a specified amount of technical assistance and travel from the Manoff Group to support the communications component of the Indramayu OR project over the 21 month life of the project. A preliminary schedule for the type and amount of TA required for the project was prepared and submitted to MotherCare by Manoff Group staff here in Washington, based on information contained in available project documentation.

However, based on the accelerated information needs of the project and the revised social marketing workplan developed with project staff during this visit, it seems that this TA schedule should be revised, and TA should be concentrated into the period between now and October 1991 when the IEC materials are scheduled to be introduced. This represents a shift in the timing of the current configuration of TA to the project, but may not necessarily increase the overall amount of TA required.

The design and time frame of the OR project is necessitating an extremely condensed schedule for the formative research and materials production, in order to have improved health education
materials available to adequately test the IEC intervention (if the allotted six months is considered an adequate time). Thus, rapid and intensive technical assistance, if requested by project staff, should be made quickly available by MotherCare to support the staff's efforts in the many tasks associated with the formative research, concept testing, strategy formulation, and materials production steps in social marketing. It is difficult to imagine that quality research, strategy design, and materials design and production using the social marketing approach could result by October 1991, without increased external assistance, given the multiple responsibilities of project staff.

3. The overall plan for the iron compliance study should be reviewed with attention given to evaluation. This TA visit was limited to work with project staff on the social marketing/communications component of the Indramayu OR project. The OR design allows a very short time period (six months) for implementation of the planned IEC intervention. Very finely tuned baseline survey measures and other evaluation indicators will be required to measure the types of changes in behavior which would be expected during such a short time frame.

Issues such as this are well beyond the scope for this TA visit. Discussion of these and related issues, which impact both the OR study and IEC component, with Population Council staff responsible for design and evaluation of the larger OR study should be undertaken as soon as possible, to assure better coordination and integration of the communication/IEC intervention with the aims and objectives of the larger study.

D. Follow-up Required

1. Communication with project staff in Jakarta should be initiated by MotherCare/Manoff as soon as possible in March 1991, to request an update on progress on the qualitative research, and any schedule changes or problems with implementation of the research. Additional TA needs and dates should be requested from Dr. Utomo as soon as possible.

2. The consultant will compile and send by mail several key reference materials on social marketing, and formative research design and techniques to project staff on return to Washington.

III. Tanjungsari Project

A. Background

The project proposal for the "Pilot Study of a Perinatal Regionalization Network" project, to be funded by MotherCare over a 33-month period, was still under review by the AID Contracts Office at the time of this TA visit. The project, as described
in the proposal and by project staff at the University of Padjadjaran in Bandung, is designed to address causes of maternal and neonatal morbidity and mortality identified in the project area during to 1987 to 1989 by the Risk Approach Study (RAS). Proposed project activities include: improving quality of care at referral centers, strengthening the referral system between TBAs, who attend the majority of childbirths in the project area, and the formal health system, establishing roadside maternity huts in several areas to facilitate emergency transport for high risk women identified by TBAs, and community maternal health education to increase awareness of select maternal health issues, using a social marketing approach.

There are approximately 90,000 residents of the rural subdistrict (kecamatan) of Tanjungsari, one hour by car from Bandung. There is a heightened awareness of the concept of maternal risk among TBAs in the project area, many of whom participated in the RAS.

B. Trip Activities

A brief trip to Bandung was scheduled to discuss the overall steps required for the social marketing component of the project, assist staff in thinking through and expanding documentation of the IEC/social marketing component of the project as described in the proposal, and develop a social marketing workplan and budget. The Principal Investigator and the sociologist responsible for development and implementation of the project IEC activities were not available to participate in discussions.

Activities during the two-day site visit included:

Site Visit

The consultant made a brief site visit to Tanjungsari. We visited the health center (PusKesMas) and a village health post (Posyandu). The PusKesMas doctor accompanied us on the site visit, and provided additional perspective to the orientation to project staff and activities there. We travelled the difficult, hilly terrain to a distant village, and visited the home of a project interviewer to review record keeping books used in the recent RAS study.

Review of Steps in Social Marketing

Discussions took place with available project staff to review the basic concepts of a social marketing approach to IEC, and of specific steps in a social marketing plan. Social marketing support materials were distributed to staff (See Appendix E). We also reviewed the formative research and materials production experience of project staff and those required for successful implementation of the communications component. Two young staff members, a Sociologist/ Research Assistant (Dra. Lubis) and an
Interviewer/Supervisor (Mr. Nugraha) will have primary responsibility for the day to day communications activities. General oversight of IEC activities will be provided by Dr. Sutedja.

**Development of Draft Social Marketing Workplan and Budget**

An intended focus of the visit was to assist staff to more clearly define the communication objectives of the project, as this must form the basis of any further planning for the SM budget and workplan. Unfortunately, all of the key personnel were not available to contribute to this discussion. Therefore, although a draft workplan and budget for the IEC/communication component were developed (See Appendix F), they are based on preliminary ideas of which areas of maternal and neonatal health and nutrition might be the focus for the communications work.

Early recognition of danger signs of pregnancy, intrapartum and neonatal periods, were suggested as major IEC focus areas by the PI during a brief telephone conversation prior to her departure. During the site visit, Dr. Thouw suggested promoting increased use of the proposed roadside "maternity huts" which will be part of project activities. Both of these ideas fit well with overall MotherCare communication and behavior change objectives for increasing awareness of maternal and neonatal health issues at the community level.

A draft social marketing workplan and budget were developed and discussed with project staff (See Appendix F). These documents reflect the need for on-site local technical assistance for most steps of the social marketing/communications component.

C. **Conclusions and Recommendations**

1. As soon as possible after contract approval, MotherCare should suggest a follow up TA visit to expand and finalize the planning of the IEC component, either according to the present design, or with significant decrease in of size and scope.

Prior to that TA visit, MotherCare and Manoff staff should meet to formulate their recommendation to Tanjungsari project staff and the USAID Mission regarding feasibility of a full scale communications component, given available resources.

The proposed Tanjungsari project activities and interventions are designed to address barriers to improved maternal and neonatal health at many levels. Development and implementation of the communications component concurrent with such a wide range of activities will require a high degree of planning, supervision and support.

The communications social marketing plan currently proposed is ambitious and requires experience and expertise in many different
technical areas: maternal health, qualitative research, and materials design and production. Technical requirements for some of these areas will require substantial additional input to complement the skills of existing project staff assigned to IEC responsibilities. Of immediate concern is the available expertise to design and conduct the formative research phase of the proposed communications component.

D. Follow-Up Required

1) Following a thorough discussion and description of the steps in the social marketing process, and the requirements of the formative research phase, it was tentatively agreed with project staff who participated in the meeting that additional local expertise, (above that which could be supplied through periodic MotherCare technical assistance by the Manoff Group), would be required to complete the IEC component as currently conceived by local project staff. This should be presented to the Principal Investigator on her return, for her consideration and concurrence.

2) As additional costs of such technical assistance will depend on scope and focus of the communication component chosen, and more in-depth review of skills of current staff, discussions similar to those which took place during this brief visit should be repeated when all key project personnel are available to participate.

Plans for the scope and content of the communications component of the project may need to be reassessed and scaled down, to more closely align with available project and MotherCare resources. Perhaps use of existing educational materials would be possible. After the project proposal is approved in Washington, additional MotherCare/Manoff technical assistance can be requested by project staff for this purpose.

3) If, after further discussion between MotherCare and project staff, it is decided that local consultants will be used, development of a scope of work and identification of a suitable person/group in Indonesia will be required. There is a school of mass communication in Bandung which might be a source of required technical support, but there was no time available to visit during this trip.

IV. General Recommendation

Larger amounts of MotherCare/Manoff technical assistance than originally expected will be required to achieve the proposed IEC objectives of the two projects in Indonesia. Although the technical focus of each project is distinctly different (iron compliance in Indramayu, and early recognition of maternal and
neonatal danger signs in Tanjungsari), the size, methodology and approach of each are essentially similar. That means that some technical assistance visits could be for work on both projects. However, this will not always be possible. Now that there is a workplan, at least for Indramayu, it is a good time to review technical assistance requirements.

Coordinating TA visits so that one Maternal Health/IEC consultant could provide TA to both projects within a given visit could substantially maximize use of available central MotherCare TA resources.
APPENDIX A

List of Persons Contacted
List of Persons Contacted

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Dr. Sutedja, Skm.

Dra. Maya Lubis
Sociologist/Research Assistant

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Interviewer Supervisor
APPENDIX B

Social Marketing Workplan and Budget
INDRAMAYU PROJECT
# SOCIAL MARKETING WORK PLAN (INDRAMAYU)

<table>
<thead>
<tr>
<th>STEP</th>
<th>TIME REQ'D/ DATES</th>
<th>J F M A M J J A S O N</th>
<th>Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DEVELOP SOCIAL MARKETING PLAN - objectives, Strategies, budget, time frame, resources</td>
<td>3 weeks</td>
<td>01/91</td>
<td>x</td>
</tr>
<tr>
<td>2. CONDUCT FORMATIVE RESEARCH</td>
<td>2 weeks</td>
<td>01/91</td>
<td>x</td>
</tr>
<tr>
<td>A. Develop qualitative research protocol</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- develop interview guides</td>
<td>2 weeks</td>
<td>02/91</td>
<td>x</td>
</tr>
<tr>
<td>- train interviewers</td>
<td>4 weeks</td>
<td>03/91</td>
<td>x</td>
</tr>
<tr>
<td>- pretest guides/revise</td>
<td>4 weeks</td>
<td>03/91</td>
<td>x</td>
</tr>
<tr>
<td>- conduct interviews</td>
<td>4 weeks</td>
<td>03/91</td>
<td>x</td>
</tr>
<tr>
<td>B. TEST INTERVENTION STRATEGY (CONCEPT TEST)</td>
<td>4 weeks</td>
<td>04/91</td>
<td></td>
</tr>
<tr>
<td>- Develop &quot;add-on&quot; to question guides to accompany distribution of iron tablets to small group of women</td>
<td>1 wk (2 wks)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>- Distribute iron tablets at time of depth interview</td>
<td>1 wk (2 wks)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>- Return to ask follow-up question on acceptability of tablet</td>
<td>1 wk (2 wks)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>3. ANALYZE FORMATIVE RESEARCH/CONCEPT TEST RESULTS AND WRITE REPORT</td>
<td>4 weeks</td>
<td>05/91</td>
<td>x</td>
</tr>
<tr>
<td>4. STRATEGY WORKSHOP TO PRESENT RESULTS, PLAN AND REFINE INTERVENTION</td>
<td>1 week</td>
<td>06/91</td>
<td>x</td>
</tr>
<tr>
<td>STEP</td>
<td>TIME REQ'D/DATES</td>
<td>JFMAMJJASOND</td>
<td>FMAJMJJASON</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>5. DEVELOP COMMUNICATION PLAN</td>
<td>6 weeks</td>
<td>06/91 - 07/91</td>
<td>x x</td>
</tr>
<tr>
<td>- Define target audiences, messages, channels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Develop media plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*produce creative/media brief</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*appoint creative team</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. DEVELOP DRAFT MESSAGES &amp; MATERIALS</td>
<td>4 weeks</td>
<td>07/91 - 08/91</td>
<td>x</td>
</tr>
<tr>
<td>- Produce sample for each media</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. PRETEST MESSAGES/MATERIALS</td>
<td>4 weeks</td>
<td>08/91</td>
<td>x</td>
</tr>
<tr>
<td>- Design pretest protocol and instruments</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Train staff</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Conduct pretest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. ANALYSE RESULTS/REVISE MESSAGES</td>
<td>08/91</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>9. PRODUCE FINAL MATERIALS</td>
<td>09/91</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>10. TRAIN USERS OF MATERIALS</td>
<td>09/91</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>11. LAUNCH (IMPLEMENTATION)</td>
<td>10/91</td>
<td></td>
<td>x</td>
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</table>
| 12. MONITOR --------> EVALUATION | Ongoing | | | x x x x x x x x x x x x x x x x x
### Proposed Budget (Local Costs) of Social Marketing Component

**INDRAMAYU**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Rupiah</th>
<th>US $</th>
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<tbody>
<tr>
<td><strong>1. Formative Research</strong></td>
<td></td>
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<tr>
<td>Local transport</td>
<td></td>
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</tr>
<tr>
<td>Depkok - Indramayu</td>
<td>160,000</td>
<td>80.00</td>
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<tr>
<td>4 trips @ 40,00</td>
<td>180,000</td>
<td>94.00</td>
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<tr>
<td>in Indramayu 15 days @ 3,000/day</td>
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<tr>
<td>Interviewer per diem</td>
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<td>21.00</td>
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<td>2 x 15 days @ 20,000/day</td>
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<tr>
<td>test intervention (return to household for follow-up visit)</td>
<td>500,000</td>
<td>263.00</td>
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<tr>
<td><strong>2. Strategy Workshop</strong></td>
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<td>1,052.00</td>
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<tr>
<td>(in Jakarta or Depok)</td>
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<tr>
<td><strong>3. Communication Materials ILLUSTRATIVE - MATERIALS DETERMINED AFTER RESEARCH</strong></td>
<td></td>
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<tr>
<td>Production</td>
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<td></td>
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<tr>
<td>Counselling materials</td>
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<td></td>
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<tr>
<td>kaders: 5-10 per posyandu 60-80 at 5,000 each copy</td>
<td>2,500,000</td>
<td>1,315.00</td>
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<tr>
<td>dukun bayi: 50 x 5,000</td>
<td>2,500,000</td>
<td>1,315.00</td>
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<tr>
<td>Pamphlet</td>
<td>5,000,000</td>
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<tr>
<td>1,000 x 5,000 each pamphlet</td>
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<td></td>
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<tr>
<td>Billboard 10 at 50,000 each</td>
<td>500,000</td>
<td>263.00</td>
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<tr>
<td>Iron action sheet 1000 pregnant women 200 Rupiah each</td>
<td>200,000</td>
<td>105.00</td>
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<tr>
<td>Radio spots: 2/day x 2 stations</td>
<td>10,800,000</td>
<td>5,684.00</td>
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<td>20,000/spot x 9 months (270 days)</td>
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<tr>
<td>Traditional Performances</td>
<td>50,000</td>
<td>26.00</td>
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<tr>
<td><strong>Design ----- 5 print items (poster, billboard, action card, etc.)</strong></td>
<td>975,000</td>
<td>500.00</td>
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<tr>
<td><strong>Write/record ---- 5 radio spots</strong></td>
<td>975,000</td>
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<tr>
<td><strong>4. Pretest Materials (similar to research costs above)</strong></td>
<td>800,000</td>
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<tr>
<td><strong>5. Training</strong></td>
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<td></td>
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<tr>
<td>500 kader x 5,000</td>
<td>2,500,000</td>
<td>1,315.00</td>
</tr>
<tr>
<td>50 dukun bayi x 5,000</td>
<td>250,000</td>
<td>155.00</td>
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<tr>
<td><strong>6. Field Monitoring</strong></td>
<td>1,000,000</td>
<td>526.00</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>30,930,000</td>
<td>16,166.00</td>
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</table>
APPENDIX C

Qualitative Research Plan and Instruments
INDRAMAYU PROJECT
QUALITATIVE RESEARCH PLAN INDRAMAYU PROJECT IRON: COMPLIANCE

Methods

Information will be collected through use of in depth interviews. Interview guides have been prepared in draft form for pregnant and recently delivered women, traditional birth attendants (dukun bayi); and kaders, and midwives (bidan) and doctors in the study area. In addition, interviews will be conducted among a small number of husbands of pregnant or recently delivered women, and among elder women family members of pregnant women, who might influence compliance with iron tablets among pregnant women.

Timeframe

The draft instruments will be pretested in the study community during February 1991, and interviewers will continue training in depth interview techniques. Revisions indicated by the pretest process will be completed by end of February.

Interviews will take place in March, over a three week period. Two interviewers will have primary responsibility for interviews of women and dukun bayi. Two additional interviewers will assist with the health staff interviews.

Sample Strategy

The project area includes approximately 10,000 households, and an estimated 1200 pregnant women according to most recent count.

A total of 30 pregnant and recently delivered women will be interviewed. Pregnant women should be in their second or third trimester of pregnancy. As current MOH policy dictates that one iron tablet daily be taken by pregnant women beginning in the sixth month of pregnancy, and continuing into the postpartum period, in the Indonesian setting, pregnant women, even in second trimester, are not necessarily eligible to receive iron through government health facilities, and therefore would not be expected to have experience with consumption/compliance of iron tablets during the current pregnancy.

Identification information collected prior to the interview will indicate parity and level of use of antenatal care during this pregnancy. Half of interviews will be among previous users of iron, and half among non users.

Six bidans (midwives) are currently working in the study area, and all will be included in the interview process. There are two doctors who will be interviewed.

At least 10 kaders and 12 dukun bayi will be interviewed. Half of the dukun bayi will be trained, half untrained.

20 interviews will be conducted among possible influencers in the community, 10 elder women with pregnant or recently delivered women in the household, and ten among husbands of pregnant or recently delivered women.

Total number of interviews is at least 78. This number might be increased slightly if patterns of information are not readily recognizable after the planned number of interviews in each category.
Overall Research Objectives: Formative Research on Iron Compliance in Pregnancy Component:

1. To identify the behavioral, attitudinal or other factor which affect pregnant women's compliance with iron supplementation
2. To identify sources of information/advice about pregnancy within the community and influencers who could influence compliance with iron supplementation
3. To identify current channels or communication/media preferences for use in dissemination of iron related IEC
4. To identify current channels of distribution of iron tablets to pregnant women
5. To determine the acceptability of several proposed alternative iron tablet delivery systems in the community, to both pregnant women and health providers
6. To explore the level of awareness, use and attitudes toward iron in pregnancy of both women and providers of maternal health care (formal and non formal)
7. To conduct concept testing on limited basis to get feedback from a small sample of pregnant women on iron tablet acceptability

Formative Research Topic Areas

Pregnant Women

1. Attitude toward pregnancy in general, and this specific pregnancy
   - Planned pregnancy?
   - Aspiration for pregnancy outcome, both for baby and maternal

2. Ethnomedical view of pregnancy
   - Awareness of relationship between blood and health
   - Beliefs regarding effects of low bloods
   - Blood loss on health
   - Awareness of anemia as an illness (symptoms, sequelae such as hemorrhage, LBW)
   - etiology
   - perceived susceptibility
   - severity
   - personal experience with anemia or sequelae

3. Perceived value of preventive action during pregnancy
   - self care practices
   - use of Antenatal Care
   - early care for self detected problems of pregnancy

4. Perceived value of iron supplementation during pregnancy
   - need for and effectiveness of iron tabs
   - personal experiences with iron supplementation (use, non use, duration of use)
- consequences of use/non use of iron
- other traditional or self care for treatment of anemia in pregnancy
- compatibility of iron supplementation with traditional ethnomedical practices during pregnancy

5. Circumferences of iron supplementation (prior experience)
- attitude toward pill taking ((size, color, taste, mode of delivery (tab, cap, tonic, IM))
- dose
- timing
- frequency
- duration
- with meals
- How iron tabs obtained
- from whom
- how often
- level of health education provided with iron tabs (treatment, instructions, comprehension/recall adherence to instructions/education)
- Opinion of source of iron tabs (dukun bayi, bidan, kader, others)

6. Barriers to use
- difficulties in access to ANC
- cost transport
- distance no tabs at posyandu
- not given tabs
- unaware of need for cost of tabs
- given but not instructed in use

7. Source of information on iron/anemia during pregnancy
8. Media preferences/communication channels
9. Iron tablets distribution (concept testing)
IDENTIFICATION

1. Name:
2. Age:
3. LMP (current month of pregnancy): (should be 6 month)
4. Date of Last Birth:
5. Parity: 0 1 2 3 4 or more
6. Previous Pregnancy Outcome(s):
   . normal
   . maternal problem -------
   . neonatal problem -------
7. Level of education/Literacy:
8. Iron tablet use:
   . never used
   . used in previous pregnancy
   . used this pregnancy
9. Antenatal care use:
   . never
   . visits this pregnancy 0 1 2 3 4 5 6 or more
   . month of pregnancy at time of ANC visit ---------
   . reason for visit (s)
8. Distance from:
   . Posyandu
   . Puskesmas
   . Kader
   . Dukun bayi
   . Hospital

INTRODUCTION

I. We would like to ask you some questions about your pregnancy (explain briefly)
   Was this pregnancy (or most recent pregnancy) planned?
   Does having a baby now cause any problems for you?
   What kind?
   Overall, how have you been feeling during this (or previous) pregnancy?
   What thought/hopes/fears do you have about your own health during pregnancy and delivery?
   For the family during this pregnancy?
   Do you notice any changes in your health during this pregnancy? What changes?
   Have you had to change your daily activities in any way because of your health during this pregnancy? How?
   Are you doing anything different since you became pregnancy? What?
   Any traditional ceremonies?
Are you taking any medicines (obat), jamu, traditional remedies or other things especially for your pregnancy? What? Why?
What about your diet? Any changes in your diet? What changes? Why?

II. Do you know of any problems which pregnant women can have with their health?
Where do you usually go for advice about these problems?
What advice did you receive there?
Do you know of any problems in pregnancy caused by blood/low blood/bleeding?
If yes, what is this called? What are the symptoms?
If necessary, prompt: tired, weak, dizzy, rapid heartbeat, ---- tired
- weak
- dizzy
- rapid heartbeat
- headache
Do you know any problems a pregnant woman can have if she has anemia (use local name for anemia here if women has given you one)? What?
Do you know of any problems pregnant women can have if they lose blood during childbirth?
What?
Has this ever happened to you or anyone you know?
What do you think causes this to happen?
Is there anything you can do prevent this from happening? What?
Do you know anything you can do to cure this problems?
- self care
- dukun bayi
- household care
- posyandu
- dukun
- other
Have you ever done any of this things?
- what was the result?
- condition improved
- no change condition worsen

III. Some pregnant women take iron tablets during their pregnancy.

Have you ever heard of pregnant women taking iron tablets?
Do you know why they take them?
Where did you hear about it?
Has anyone you know taken them?
Have you taken them?
When did you first take iron?
- this pregnancy 6 7 8 9 month
- previous pregnancy
- other
When is the last time you took iron tablet?
How many did you take?
Did you stop before you took all the tablets you were given? Why?
Were there any problems which you had because of the iron tablets?
What type of problems?
If no response, prompt:
- constipation
- diarrhea
- change in color/consistency of stool
- vomiting
IV. I am going to ask you a few questions about the tablets.
Is there anything about the tablet which you do not like, or which makes it difficult for you to continue taking the tablet?
Probe: - size
- taste
- difficulty swallowing
- color

Would you find it easier to take iron in some other form?
Probe:
- jamu/tonic
- injection
- other

Did you notice any change in your health or how you were feeling after taking the iron tablets?
What?
How long were you taking the tablets before you noticed these changes?
Where did you get the iron tablets?
Who gave them to you?
How often do you have to go back and get more?
Is this difficult for you?
Do you usually return to get more tablets?
Can you remember what the person who gave you the iron tablets told you about how to use them?
Probe:
- When to take
- How long to take
- How many to take
- What to do if side effects occur
- reason for iron pills
- when to return for more tabs
- explain side effects
- other

Did you follow these instructions? Why/Why not?
Did anyone else give you advice about iron/anemia in pregnancy? Who?
- bidan/nurse
- kader
- husband
- dukun bayi
- mother
- community leader
- mother in law
female friend
other

What did they tell you?

V. Did you ever hear about iron on the radio? TV? What did the messages say?
Have you seen posters about iron in pregnancy? at the Posyandu? Where? What did the posters say?
Can you think of any other way that would be easier for you to get iron tablets than the way you are getting them now? Which way?
Do you have any problems getting to the Posyandu or other source of iron tabs? What problems?
Can you think about any other problems with iron tablets other than those we have already discussed? Any other comments?
Do you have any iron tablets in the house now? Can you show them to me?
- type
- amount
- where stored

Do you have any other tablets or medicines in the house? Jamu, tonics or other obat? Can I see them?

VI. Media Preference/Channels of Communication
Do you listen to the radio?
- How often?
- What stations?
- What times?
- What are your favorite programs?
Do you usually do other things while you are listening to radio, or only listen?
Who listens with you?
Do you have a TV? Do your neighbors have a TV? How often do you watch TV? What stations? What programs? What times? Who watches with you?

How often do you read newspapers, magazines?
Which ones?
Where would you prefer to learn more about iron tablets?
When you go out of the house each day, where do you usually go? How often do you go each week?
- market (weekly market or smaller daily market or food stalls)
- mosque
- cinema
- PKK
- selamatan
- arisan
- other

How often do you go to the posyandu? To puskesmas? To private clinic or private doctor? To dukun bayi? Apotik? Other

Is this different than before you were pregnant? How?
Concept Test Interview Guide for Pregnant Women

(to be used at return visit to same women who received 10 days of iron/folate tablet at time of initial In Depth Interview)

Greet the woman.

How have you been feeling since the last visit? Any problems?

Did you remember to take the iron tablets I left with you? Why? Why not?

How many did you take? How often? Did you take them with meals?

Do you have any tablets remaining? Can you show them to me? Count remaining tablets.

Did you notice any changes in how you feel while you were taking the tablets? What kind of changes? Problems? Benefits?

Do you remember why we told you that it is important to take iron?

What do you think now that you have tried the iron tablets yourself?

Will you continue taking them throughout your pregnancy? Why? Why not?

Can you think of any reasons why it might be difficult for you to continue taking the tablets?

Did anyone in your family or any of your friends notice that you were taking the iron tablets? Did they make any comments or give you any advice? What?

Would you go to the posyandu for more iron tablets? The puskesmas?

What about going to the home of the dukun bayi for more iron tablets? Why, Why not?

Would you like me to leave some more iron tablets with you today? Why, Why not?
How many pregnant women do you usually care for/visit each month? How many are you caring for/visiting now?

Are there many pregnant women in your area who you do not care for? How many?

Are there some common problems which pregnant women usually ask your advice about? What kind of problems?

What advice do you usually give them?

Any other things that pregnant women talk to you about?

Who else do you think pregnant women talk to about their health during pregnancy?

Have you ever heard of a problem in pregnant women called kurang darah (anemia)?

Can you tell me what it is? What causes it? Is there any way to prevent it?

How do you know if a pregnant woman, or any woman, has anemia?

Do you know of any problems to health which can be caused by anemia in pregnant women? Which problems?

What do you advise pregnant women to do if you think she has anemia?

Do most women follow this advice?

Are there any other things you tell them to do?

Have you heard of taking iron tablets during pregnancy? (if this was not part of the answer to previous question)

Do you know why pregnant women take them?

Do you ever tell women to take iron tablets?

If so, where do you tell them to get the tablets?

Have you ever taken iron tablets yourself? When? Why? How long?

Did you notice any change in your health (how you felt) after taking the tablets?
How do most pregnant women you know get iron tablets now?

Do they have problems getting the tablets? What problems?

Would you be willing to distribute iron tablets to pregnant women in your area?

Do you think it would be possible for pregnant women to come to your house to receive iron tablets?

What about someone delivering iron tablets to the home of each pregnant woman? Who do you think could do that? Would you be willing to deliver iron tablets to the homes of pregnant women in your area? Why Why not?

Can you think of any other way that pregnant women could receive iron tablets?

Any other things you would like to discuss?
How common is anemia in pregnant women in this area? About what percentage of all the pregnant women you care for have anemia?

How do you usually determine that a woman is anemic? Any reason why you use this method? Any problems with this method?

How serious do you think anemia is as a problem for pregnant women? Are there other problems that you usually see in pregnant women which you think are more serious than anemia? Which?

Are there programs for prevention or treatment of anemia in this area? Can you describe them? In your opinion, are these programs effective?

What could you suggest to improve the effectiveness of the current program?

When you give iron tablets to pregnant women, do you give them any advice? On how to take the tablets? On why it is necessary to take the tablets? On possible side effects? Anything else you usually tell them?

Do you think the women take the tablets you give them? Why or why not? Do women usually give you any reason why they are not taking the iron tablets? Do many women return for resupply of the iron tablets throughout their pregnancy?

Do you know of any difficulties which may prevent pregnant women from obtaining iron tablets?

Do you know of any other medicines, tonics, jamu or other traditional medicines which pregnant women commonly take? Are any of these used for anemia?

How do pregnant women receive iron tablets now? How do those women who do not attend posyandu or puskesmas obtain iron tablets?

Can you suggest any other ways or locations which might be used to distribute iron tablets to pregnant women? Who might be appropriate person to distribute iron tablets at places other than health facilities?

Any other things which might make it easier for women to receive and take iron tablets? Can you think of any benefits or problems that might occur if iron tablets were distributed in the community, rather than only at health facilities?
INTRO/GREETING

What is your relationship to the pregnant woman in this household?

Overall, how would you say she has been feeling during this current pregnancy?

Is it different than her other pregnancies? (if this is not her first)

How?

Does she ever tell you about problems she is having during her pregnancy? What problems?

What advice do you give her?

Is there someone else you think is good for pregnant women to talk with when they have these problems?

Who? Do you send (the pregnant woman in this house) there? Does she go?

Do you think pregnant women should talk to/receive care from someone even if they do not have problems? Why, why not? Who?

Are pregnant women doing anything differently than when you were last pregnant? What? How do you feel about these new things that pregnant women do?

Are they having any problems that are different than when you yourself were last pregnant? Which?

Do you know of any problems in pregnancy caused by blood/low blood/bleeding? How would you know if (the pregnant woman in this house) had this problem?

Have you heard of a problem called anemia? Can you tell me anything about it?

Has this happened to you? To anyone you know? Do you think it is a serious problem? Is there anything that can be done to prevent this from happening? What can cure it?

Has (the pregnant woman in this house), or you or anyone you know ever done these things? What happened?

Some pregnant women take iron tablets during their pregnancy. Have you ever heard of this?

Do you know why they take iron tablets? Where did you hear about it?

Has (the pregnant woman in this house) or any woman you know taken them? Have you yourself ever taken them?

Do you know where they got the tablets?

How long did she take them? Why did she stop?

Did (the pregnant woman in this house) tell you anything about the tablets while she was taking them? What?
Did you tell her anything about the tablets? What? Where did you get the information which you gave her about the tablets?

Did you notice any change in her health while or after she was taking the iron tablets? What changes?

Do you think it is necessary for pregnant women to take iron? Why, why not?

Do you think it would be possible for (the pregnant woman in this house) to go to posyandu to get iron tablets? Why, why not?

To puskesmas to get iron tablets? Why, why not?

To the house of the dukun bayi? Why/ why not?

Where else would it be possible for pregnant women to go to get iron tablets? Why do you think this is a good idea?

Would you advise (the pregnant woman in this house) to go there to get tablets? Why, why not?

Do you think it would be possible for the dukun bayi to come here to your house to deliver iron tablets to (the pregnant woman in this house) Why, Why not?

Do you know of any other special things (the pregnant woman in this house) or other women do when they are pregnant? What things? Do you think these things are necessary?

Media/ Communication

Before we began talking, did you ever hear about iron tablets for pregnant women? Where? on radio? TV? at the posyandu or puskesmas?

How often do you go to the posyandu? Why Puskesmas? Why?
How often does (the pregnant woman in this house) go to posyandu? Why? Puskesmas? Why?

Is there a radio in your house?
How often do you listen? What station? What programs? What times?

Do you have a TV? Do you ever see TV? Where how often What programs What times?

How often do you read newspapers, magazines? Which ones?

Do you attend market? Mosque etc (use the same list from the pregnant woman media question guide here) When How often
HUSBAND DEPTH INTERVIEW  INDRAMAYU IRON COMPLIANCE

INTRO/GREETING

Overall, how would you say your wife has been feeling during this current pregnancy?

Is it different than her other pregnancies? (if this is not her first) How?

Does your wife ever tell you about problems she is having during her pregnancy? What problems?

What advice do you give her?

Is there someone else you think is good for pregnant women to talk with when they have these problems? Who? Do you send your wife there? Does she go?

Do you think pregnant women should talk to/receive care from someone even if they do not have problems? Why, why not? Who?

Do you know of any problems in pregnancy caused by blood/low blood/bleeding? How would you know if your wife had this problem?

Have you heard of a problem called anemia? Can you tell me anything about it?

Has this happened to anyone you know? Is there anything that can be done to prevent this from happening? What can cure it?

Has your wife or anyone you know ever done these things? What happened?

Some pregnant women take iron tablets during their pregnancy. Have you ever heard of this?

Do you know why they take iron tablets? Where did you hear about it?

Has your wife or any woman you know taken them?

Do you know where they got the tablets?

How long did she take them? Why did she stop?

Did your wife tell you anything about the tablets while she was taking them? What?

Did you notice any change in her health while or after she was taking the iron tablets? What changes?

Do you think it is necessary for pregnant women to take iron? Why, why not?

Do you know of any other special things your wife or other women do when they are pregnant? What things? Do you think these things are necessary?
Before we started the talking did you ever hear about iron tablets for pregnant women? Where? on radio? TV? at the posyandu or puskesmas?

How often do you go to the posyandu? Why? Puskesmas? Why?
How often does your wife go to posyandu? Why? Puskesmas? Why?

Is there a radio in your house?
How often do you listen? What station? What programs? What times?

Do you have a TV? Do you ever see TV? Where how often What programs What times?

How often do you read newspapers, magazines? Which ones?

Do you attend market? Mosque etc When How often
APPENDIX D

Module D:  Indramayu Health and Family Planning
Prospective Study
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of gravida (including this pregnancy):</td>
<td></td>
</tr>
<tr>
<td>2. Number of abortions:</td>
<td></td>
</tr>
<tr>
<td>3. Number of stillbirths:</td>
<td></td>
</tr>
<tr>
<td>4. Number of livebirths:</td>
<td></td>
</tr>
<tr>
<td>5. Number of children still alive:</td>
<td></td>
</tr>
<tr>
<td>6. Type of preceding pregnancy outcome:</td>
<td></td>
</tr>
<tr>
<td>7. Date of preceding pregnancy outcome:</td>
<td></td>
</tr>
<tr>
<td>8. Date of preceding pregnancy onset:</td>
<td></td>
</tr>
</tbody>
</table>

9. Before you became pregnant this time, had you done anything, even for a short time, to avoid getting pregnant or having birth? Yes - Go To 9.2 / No - Go To 9.1

9.1 Did you plan to become pregnant and have a child now? (Y/N) If Yes - Go to 9.2

9.1.1 If No, did you plan to wait until later (Y/N) (Y/N)

9.1.2 If No, did you plan no more children at all (Y/N)

9.2 What was the last family planning method used? (Coding)

10. Did you become pregnant while you were still using (last method)? Yes - Go to 10.2 / No - Go To 10.1

10.1 If No, did you plan to become pregnant and have a child now (Y/N)

10.1.1 If No, did you plan to wait until later (Y/N): If Yes - Go to 10.2

10.1.2 If No, did you plan no more children at all (Y/N)

10.2 Have you ever taken herb/jamu in early pregnancy (Y/N)

10.2.1 If Yes, specify (sample to be collected by interviewer)

10.3 Have you ever had abdominal massage in early pregnancy (Y/N)

11. Have you or your husband smoked in the past? (Y/N)

12. Are you or your husband smoking now? (Y/N)

12.1 If Yes, how many cigarettes per day?

13. Did you drink coffee in the past? (Y/N)

14. Are you drinking coffee now? (Y/N)

14.1 If Yes, how many glasses per day?

15. Did you chew tobacco in the past? (Y/N)

16. Are you chewing tobacco now? (Y/N)

16.1 If Yes, how many times per day

16.2 If Yes, how many times per week

16.3 If Yes, specify type (beer, whiskey, wine etc)

16.4 Number of glasses per week

BEST AVAILABLE
19. ON HOW MANY DAYS IN THE PAST WEEK DID YOU EAT OR DRINK THE FOLLOWING FOOD ITEMS?

<table>
<thead>
<tr>
<th>FOOD ITEMS</th>
<th>DATE OF INTERVIEW</th>
<th>DATE OF INTERVIEW</th>
<th>DATE OF INTERVIEW</th>
<th>DATE OF INTERVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of days</td>
<td>Freq/day</td>
<td>Number of days</td>
<td>Freq/day</td>
</tr>
<tr>
<td>Rice</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Corn</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Cassava/Manioc</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Potato</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Sweet Potato</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Bread</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Fresh fish</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Shrimp/crab/clam</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Dried salty fish</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Eggs</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
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</tr>
<tr>
<td>Beef, Lamb (Meat)</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
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<tr>
<td>Chicken</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Corgedale blood</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Milk</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
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</tr>
<tr>
<td>Nut</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Coconut</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Vegetables</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Green Leaves</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Banana</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Pineapple</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Mango</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Papaya</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Citrus fruits</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
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<tr>
<td>Jambos</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Durian</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Manggis</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Cabbage</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Carrot</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Bean Sprouts</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Tomato</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

20. Cooking oil used in the last month.
21. Since last visit, did your food intake increase/remain constant/decrease? (Coding)

22. Since last visit, did you avoid eating any food because of pregnancy? (Y/N)
   22.1. If Yes, specify
   22.2. If Yes, did you eat the above food before pregnancy (Y/N)

23. Since last visit, have you been eating any special food because of pregnancy?
   23.1. If Yes, specify
   23.2. If Yes, did you also eat the above food before pregnancy (Y/N)

24. Did you take any medication/herb since last visit for making the pregnancy safe? (Y/N)
   24.1. If Yes, specify medication
   24.2. If Yes, specify herb
   24.3. If Yes, did you take the above medication/herb before pregnancy (Y/N)

25. Do you feel any anxiety about this pregnancy? (Y/N)
   25.1. If Yes, specify

26. Have you had fever and/or chills and/or shivering since last visit? Yes - Go to 26.1
   26.1 If Yes, what did you do about it
       Got treated - Go to 27
       Nothing - Go to 28

27. Got treated
   27.1 Self treatment (Coding)
   27.2 Treated by (Coding)
   27.3 Place of treatment (Coding)
   27.4 Medication received (Coding)

28. If nothing, what were the obstacles/reasons (Specify)

29. Have you had eclampsia/convulsion since last visit? Yes - Go to 29.1
   29.1 If Yes, what did you do about it
       Got treated - Go to 30
       Nothing - Go to 31

30. Got treated
   30.1 Self treatment (Coding)
   30.2 Treated by (Coding)
   30.3 Place of treatment (Coding)
   30.4 Medication received (Coding)

31. If nothing, what were the obstacles/reasons (Specify)
<table>
<thead>
<tr>
<th>MORBIDITY</th>
<th>DATE OF INTERVIEW</th>
</tr>
</thead>
</table>
| 32. Do you have swelling of limbs/face since last visit? Yes - Go to 32.1  
  No - Go to 35 |
| 32.1 If Yes, site of swelling: Hands (Y/N) |  
  Feet (Y/N) |  
  Face (Y/N) |
| 32.2 What did you do about it?  
  Got treated - Go to 33  
  Nothing - Go to 34 |
| 33. Got treated  
  33.1 Self treatment (coding)  
  33.2 Treated by (coding)  
  33.3 Place of treatment (coding)  
  33.4 Medicament received (coding) |
| 34. If nothing, what were the obstacles/reasons (specify) |
| 35. Have you had diarrhea since last visit? Yes - Go to 35.1  
  No - Go to 38 |
| 35.1 If Yes, light/moderate/heavy |
| 35.2 How many days |
| 35.3 What did you do about it?  
  Got treated - Go to 36  
  Nothing - Go to 37 |
| 36. Got treated  
  36.1 Self treatment (coding)  
  36.2 Treated by (coding)  
  36.3 Place of treatment (coding)  
  36.4 Medicament received (coding) |
| 37. If nothing, what were the obstacles/reasons (specify) |
| 38. Have you had dark stool since last visit? Yes - Go to 38.1  
  No - Go to 41 |
| 38.1 What did you do about it?  
  Got treated - Go to 39  
  Nothing - Go to 40 |
| 39. Got treated  
  39.1 Self treatment (coding)  
  39.2 Treated by (coding)  
  39.3 Place of treatment (coding)  
  39.4 Medicament received (coding) |
<p>| 40. If nothing, what were the obstacles/reasons (specify) |</p>
<table>
<thead>
<tr>
<th>MORBIDITY</th>
<th>DATE OF INTERVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Have you had constipation since last visit Yes-Go to 41.1 No-Go to 44</td>
<td></td>
</tr>
<tr>
<td>41.1 What did you do about it? Got treated - Go to 42 Nothing - Go to 43</td>
<td></td>
</tr>
<tr>
<td>42. Got treated</td>
<td></td>
</tr>
<tr>
<td>42.1 Self treatment (coding)</td>
<td></td>
</tr>
<tr>
<td>42.2 Treated by (coding)</td>
<td></td>
</tr>
<tr>
<td>42.3 Place of treatment (coding)</td>
<td></td>
</tr>
<tr>
<td>42.4 Medication received (coding)</td>
<td></td>
</tr>
<tr>
<td>43. If nothing, what were an obstacles/reasons (specify)</td>
<td></td>
</tr>
<tr>
<td>44. Did you feel weak or easily tired since last visit Yes-Go to 44.1 No-Go to 47</td>
<td></td>
</tr>
<tr>
<td>44.1 What did you do about it? Got treated - Go to 45 Nothing - Go to 46</td>
<td></td>
</tr>
<tr>
<td>45. Got treated</td>
<td></td>
</tr>
<tr>
<td>45.1 Self treatment (coding)</td>
<td></td>
</tr>
<tr>
<td>45.2 Treated by (coding)</td>
<td></td>
</tr>
<tr>
<td>45.3 Place of treatment (coding)</td>
<td></td>
</tr>
<tr>
<td>45.4 Medication received (coding)</td>
<td></td>
</tr>
<tr>
<td>46. If nothing, what were an obstacles/reasons (specify)</td>
<td></td>
</tr>
<tr>
<td>47. Have you had persistent headache since last visit Yes-Go to 47.1 No-Go to 50</td>
<td></td>
</tr>
<tr>
<td>47.1 What did you do about it? Got treated - Go to 48 Nothing - Go to 49</td>
<td></td>
</tr>
<tr>
<td>48. Got treated</td>
<td></td>
</tr>
<tr>
<td>48.1 Self treatment (coding)</td>
<td></td>
</tr>
<tr>
<td>48.2 Treated by (coding)</td>
<td></td>
</tr>
<tr>
<td>48.3 Place of treatment (coding)</td>
<td></td>
</tr>
<tr>
<td>48.4 Medication received (coding)</td>
<td></td>
</tr>
<tr>
<td>49. If nothing, what were an obstacles/reasons (specify)</td>
<td></td>
</tr>
</tbody>
</table>
## Prenatal: Quarterly (Every 3 Months)

### Morbidity

<table>
<thead>
<tr>
<th>Morbidity</th>
<th>Date of Interview</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>50. Have you had difficulty or burning sensation during urination since last visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50.1 What did you do about it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51. Got treated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51.1 Self treatment (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51.2 Treated by (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51.3 Place of treatment (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51.4 Medicament received (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>52. If nothing, what were the obstacles/reasons?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53. Did you have severe nausea since last visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53.1 What did you do about it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54. Got treated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54.1 Self treatment (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54.2 Treated by (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54.3 Place of treatment (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54.4 Medicament received (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55. If nothing, what were the obstacles/reasons?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56. Did you have vomiting since last visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56.1 If yes, light/medium/heavy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56.2 How many days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56.3 What did you do about it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57. Got treated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57.1 Self treatment (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57.2 Treated by (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57.3 Place of treatment (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57.4 Medicament received (coding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58. If nothing, what were the obstacles/reasons?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Note: The above table is a snapshot of a form used for assessing the health status of a patient during prenatal check-ups. Each question is followed by a series of possible responses, with further questions depending on the patient's answers. The form aims to capture any symptoms or issues that might require medical attention or follow-up.
<table>
<thead>
<tr>
<th>MORBIDITY</th>
<th>DATE OF INTERVIEW</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>59. Did you have any other kind of bleeding</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>since last visit</td>
<td>Yes - Go to 59.1</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>No - Go to 62</td>
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<tr>
<td>59.1 Site of bleeding</td>
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<td>59.2 Cause of bleeding</td>
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<tr>
<td>59.3 How many days</td>
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<td></td>
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</tr>
<tr>
<td>59.4 What did you do about it?</td>
<td></td>
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<td></td>
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<tr>
<td>Get treated - Go to 60</td>
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<tr>
<td>Nothing - Go to 61</td>
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<tr>
<td>60. Got treated</td>
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<tr>
<td>60.1 Self treatment (coding)</td>
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<tr>
<td>60.2 Treated by (coding)</td>
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<tr>
<td>60.3 Place of treatment (coding)</td>
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<tr>
<td>60.4 Medicament received (coding)</td>
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<tr>
<td>61. If nothing, what were an obstacles/reasons</td>
<td></td>
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</tr>
</tbody>
</table>
### ANTENATAL CARE

62. Have you ever had prenatal check since last visit?  
- Yes - Go to 63  
- No - Go to 64

63. Yes. 63.1 Personnel contacted (coding)  
- 63.2 Medicament/examination received  
  - 63.2.1 Weighing (Y/N)  
  - 63.2.2 IF Injection (Y/N)  
  - 63.2.3 Iron folate (Y/N)  
  - 63.2.4 Tibial edema examination (Y/N)  
  - 63.2.5 Fundal height examination  
  - 63.2.6 Other, specify

64. If No, reason for not having prenatal check (coding)

### IRON CONSUMPTION

65. Have you ever heard of anemia (Y/N)  
- 65.1 If Yes, can you describe the symptoms? (Record at first visit)

66. Have you received iron folate since last visit (Y/N)  
- 66.1 If Yes, from whom  
- 66.2 From where  
- 66.3 when  
- 66.4 How many

67. Do you have any iron folate table in the house (Y/N)  
- 67.1 If Yes, please show (UNICEF or Local)

68. Have you taken iron folate since last visit (Y/N)  
- 68.1 Did you take the tablet during (B/A) before/after (B/A) meals  
- 68.2 If (B/A) how long before/after (hrs)  
- 68.3 If (B/A) what did you eat during meals

69. If No, reason for not taking (Coding)

### HEIGHT AND ANTHROPOMETRY

<table>
<thead>
<tr>
<th>Month</th>
<th>Height (cm)</th>
<th>Weight (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February</td>
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<tr>
<td>March</td>
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<td>April</td>
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<td>May</td>
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<td>September</td>
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<td>October</td>
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<tr>
<td>November</td>
<td></td>
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<tr>
<td>December</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Record monthly for Weight and Height, quarterly for Hemoglobin and Arm Circumference)
<table>
<thead>
<tr>
<th><strong>DATE OF INTERVIEW</strong></th>
<th><strong>DATE OF INTERVIEW</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outcome of current pregnancy (coding)</td>
<td>Live birth or still birth</td>
</tr>
<tr>
<td>2. If live birth, when did the baby cry after birth (coding: immediately, cry after delivery)</td>
<td></td>
</tr>
<tr>
<td>3. Any problems and encountered by the baby during the first day of life (Y/N)</td>
<td>If Yes - Go to 3.1-3.6 No - Go to 4</td>
</tr>
<tr>
<td>3.1 If Yes, body turned blue (Y/N)</td>
<td></td>
</tr>
<tr>
<td>3.2 Body turned yellow (Y/N)</td>
<td></td>
</tr>
<tr>
<td>3.3 Had breathing problems (Y/N)</td>
<td></td>
</tr>
<tr>
<td>3.4 Had feeding problems (Y/N)</td>
<td></td>
</tr>
<tr>
<td>3.5 Had fever (Y/N)</td>
<td></td>
</tr>
<tr>
<td>3.6 Other, specify:</td>
<td></td>
</tr>
<tr>
<td>4. Birth weight in grams (4 digit)</td>
<td></td>
</tr>
<tr>
<td>4.1 Date of weighing (coding: immediately, after delivery)</td>
<td></td>
</tr>
<tr>
<td>5. Length at birth in centimeters (2 digit)</td>
<td></td>
</tr>
<tr>
<td>5.1 Date of measurement</td>
<td></td>
</tr>
<tr>
<td>6. Any congenital anomalies (Y/N)</td>
<td></td>
</tr>
<tr>
<td>6.1 If yes, specify:</td>
<td></td>
</tr>
<tr>
<td>7. Sex of the baby M/F</td>
<td></td>
</tr>
<tr>
<td>8. If still birth, when did the baby stop moving before delivery (.... days)</td>
<td></td>
</tr>
<tr>
<td>9. What did the baby look like?</td>
<td></td>
</tr>
<tr>
<td>9.1 Normal big (Y/N)</td>
<td></td>
</tr>
<tr>
<td>9.2 Normal small (Y/N)</td>
<td></td>
</tr>
<tr>
<td>9.3 Normal average (Y/N)</td>
<td></td>
</tr>
<tr>
<td>9.4 Macerated (Y/N)</td>
<td></td>
</tr>
<tr>
<td>9.5 Other defect, specify:</td>
<td></td>
</tr>
<tr>
<td>10. Date of delivery / termination:</td>
<td></td>
</tr>
<tr>
<td>11. Hour of delivery / termination (coding: immediately, after delivery)</td>
<td></td>
</tr>
<tr>
<td>12. Place of delivery / termination (coding)</td>
<td></td>
</tr>
<tr>
<td>13. Birth attendant (coding)</td>
<td></td>
</tr>
<tr>
<td>14. Sex of the baby M/F</td>
<td></td>
</tr>
<tr>
<td>15. Type of delivery (coding: no instrument, instrument, operation)</td>
<td></td>
</tr>
<tr>
<td>16. Fetal presentation (coding: head, breech, transverse, don't know)</td>
<td></td>
</tr>
<tr>
<td>17. Duration of labor process: beginning of labor pain to birth (coding: &lt; 6 hours, 6-12 hours, &gt; 24 hours, don't know)</td>
<td></td>
</tr>
<tr>
<td>18. Duration between ruptured membrane and delivery (discharge from vagina) (coding: &lt; 6 hours, 6-12 hours, &gt; 24 hours, don't know)</td>
<td></td>
</tr>
<tr>
<td>19. What was the color of uterine fluid? (coding: clear as water, bloody, greenish, brown, don't know)</td>
<td></td>
</tr>
<tr>
<td>20. When did you put the baby to the mother's breast (coding: immediately, after cord was cut, later... hours after delivery)</td>
<td></td>
</tr>
<tr>
<td>21. Was the cord cut? (coding: immediately, after delivery of placenta)</td>
<td></td>
</tr>
<tr>
<td>22. What type of cord cutter was used? (coding: knife, bamboo, scissors, razor blade, other specify:</td>
<td></td>
</tr>
<tr>
<td>23. Was the cutter sterilized? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>24. Did the mother receive any drugs / treatment during labor (Y/N)</td>
<td></td>
</tr>
<tr>
<td>24.1. Massage (Y/N)</td>
<td></td>
</tr>
<tr>
<td>24.2. Herbs. (Y/N), If Yes, specify:</td>
<td></td>
</tr>
<tr>
<td>24.3. Pill (Y/N), If Yes, specify:</td>
<td></td>
</tr>
<tr>
<td>24.4. Injection (Y/N), If Yes specify:</td>
<td></td>
</tr>
<tr>
<td>24.5. Infusion (Y/N), If Yes specify:</td>
<td></td>
</tr>
<tr>
<td>24.6. Other medicine, If Yes, specify:</td>
<td></td>
</tr>
<tr>
<td>25. Did the mother receive any drugs / treatment after labor (Y/N)</td>
<td></td>
</tr>
<tr>
<td>25.1. Massage (Y/N)</td>
<td></td>
</tr>
<tr>
<td>25.2. Herbs. (Y/N), If Yes, specify:</td>
<td></td>
</tr>
<tr>
<td>25.3. Pill (Y/N), If Yes, specify:</td>
<td></td>
</tr>
<tr>
<td>25.4. Injection (Y/N), If Yes specify:</td>
<td></td>
</tr>
<tr>
<td>25.5. Infusion (Y/N), If Yes specify:</td>
<td></td>
</tr>
<tr>
<td>25.6. Other medicine, If Yes, specify:</td>
<td></td>
</tr>
<tr>
<td>26. Was the bleeding more than usual during labor (Y/N)</td>
<td></td>
</tr>
<tr>
<td>26.1. If Yes, what was done about it?</td>
<td></td>
</tr>
<tr>
<td>27. Duration between time of birth and the expulsion of placenta: minutes</td>
<td></td>
</tr>
<tr>
<td>28. Was the bleeding after the expulsion of placenta more than usual (Y/N)</td>
<td></td>
</tr>
<tr>
<td>28.1. If Yes, what was done about it?</td>
<td></td>
</tr>
<tr>
<td>29. Was there fever during labor (Y/N)</td>
<td></td>
</tr>
<tr>
<td>29.1. If Yes, what was done about it?</td>
<td></td>
</tr>
<tr>
<td>30. Was there convulsion during labor (Y/N)</td>
<td></td>
</tr>
<tr>
<td>30.1. If Yes, what was done about it?</td>
<td></td>
</tr>
<tr>
<td>31. Was the mother transferred in labor (referral) (Y/N)</td>
<td></td>
</tr>
<tr>
<td>31.1. If Yes, why, where, and how (transport)?</td>
<td></td>
</tr>
<tr>
<td>MORBIDITY</td>
<td>DATE OF INTERVIEW</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
</tr>
<tr>
<td>1. Since last visit did you have fever and chills (Y/N)</td>
<td>Yes ---+ Go to 1.1</td>
</tr>
<tr>
<td></td>
<td>No ---+ Go to 4</td>
</tr>
<tr>
<td>1.1 If Yes, what did you do about it:</td>
<td>Got treated ---+ Go to 2</td>
</tr>
<tr>
<td></td>
<td>Nothing ---+ Go to 3</td>
</tr>
<tr>
<td>2. Got treated</td>
<td>11. Got treated</td>
</tr>
<tr>
<td>2.1 Self treatment (coding)</td>
<td>11.3 Place of treatment (coding)</td>
</tr>
<tr>
<td>2.2 Treated by (coding)</td>
<td>11.4 Got treated</td>
</tr>
<tr>
<td>2.3 Place of treatment (coding)</td>
<td>12.1 Got treated</td>
</tr>
<tr>
<td>2.4 Medicament received (coding)</td>
<td>12.3 Place of treatment (coding)</td>
</tr>
<tr>
<td>3. Nothing, what were an obstacles/reasons(specify)</td>
<td>12.4 Got treated</td>
</tr>
<tr>
<td>4. Since last visit did you have any discharge from vagina (Y/N)</td>
<td>Yes ---+ Go to 4.1</td>
</tr>
<tr>
<td></td>
<td>No ---+ Go to 7</td>
</tr>
<tr>
<td>4.1 What was the colour (specify) ............</td>
<td>13.1 If Yes, what did you do about it:</td>
</tr>
<tr>
<td>4.2 Was it smelly (Y/N)</td>
<td>14. Got treated</td>
</tr>
<tr>
<td>4.3 What did you do about it:</td>
<td>14.2 Treated by (coding)</td>
</tr>
<tr>
<td></td>
<td>Got treated ---+ Go to 5</td>
</tr>
<tr>
<td></td>
<td>Nothing ---+ Go to 6</td>
</tr>
<tr>
<td>5. Got treated</td>
<td>15. Nothing, what were an obstacles/reasons(specify)</td>
</tr>
<tr>
<td>5.1 Self treatment (coding)</td>
<td>16. Since last visit did you get convulsion (Y/N)</td>
</tr>
<tr>
<td>5.2 Treated by (coding)</td>
<td>Yes ---+ Go to 16.1</td>
</tr>
<tr>
<td>5.3 Place of treatment (coding)</td>
<td>No ---+ Go to 19</td>
</tr>
<tr>
<td>5.4 Medicament received (coding)</td>
<td>17. Nothing, what were an obstacles/reasons(specify)</td>
</tr>
<tr>
<td>6. Nothing, what were an obstacles/reasons(specify)</td>
<td>17.2 Treated by (coding)</td>
</tr>
<tr>
<td>7. Since last visit did you have burning pain</td>
<td>17.3 Place of treatment (coding)</td>
</tr>
<tr>
<td>8. Got treated</td>
<td>17.4 Medicament received (coding)</td>
</tr>
<tr>
<td>8.1 Self treatment (coding)</td>
<td>18. Nothing, what were an obstacles/reasons(specify)</td>
</tr>
<tr>
<td>8.2 Treated by (coding)</td>
<td>18.2 Treated by (coding)</td>
</tr>
<tr>
<td>8.3 Place of treatment (coding)</td>
<td>18.3 Place of treatment (coding)</td>
</tr>
<tr>
<td>8.4 Medicament received (coding)</td>
<td>18.4 Medicament received (coding)</td>
</tr>
<tr>
<td>9. Nothing, what were an obstacles/reasons(specify)</td>
<td>18.5 Nothing, what were an obstacles/reasons(specify)</td>
</tr>
<tr>
<td>QUESTION</td>
<td>ANSWER 1</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td>19. Are you feeling depressed (Y/N)</td>
<td></td>
</tr>
<tr>
<td>20. Are you still bleeding (Y/N)</td>
<td></td>
</tr>
<tr>
<td>20.1. If Yes, more than usual (Y/N)</td>
<td></td>
</tr>
<tr>
<td>20.1.1 If Yes, what did you do about it</td>
<td></td>
</tr>
<tr>
<td>HEALTHCARE</td>
<td></td>
</tr>
<tr>
<td>21. Have you taken iron folate tablet since last visit (Y/N)</td>
<td>Yes ——&gt; Go to 27.1</td>
</tr>
<tr>
<td>21.1 If Yes, frequency of intake (coding: daily, occasionally, none)</td>
<td></td>
</tr>
<tr>
<td>21.2 Place of distribution (coding)</td>
<td></td>
</tr>
<tr>
<td>21.3. And dose per day (coding: once, more than one)</td>
<td></td>
</tr>
<tr>
<td>22. Did you eat with/before/after meals (Y/N)</td>
<td></td>
</tr>
<tr>
<td>22.1 If before/after did you eat is in meals (Y/N)</td>
<td></td>
</tr>
<tr>
<td>22.1.1 If yes, how long before/after? .... hours</td>
<td></td>
</tr>
<tr>
<td>23. If No, reason for refusal of iron folate tablet (coding: taste bad, constipation, black stool, do not know, others, specify:)</td>
<td></td>
</tr>
<tr>
<td>24. Did you visit hospital, health center, posyandu health personnel since previous visit (Y/N)</td>
<td>Yes ——&gt; Go to 24.1</td>
</tr>
<tr>
<td>24.1 If yes, postpartum check (Y/N)</td>
<td></td>
</tr>
<tr>
<td>24.2 Breastfeeding consultation (Y/N)</td>
<td></td>
</tr>
<tr>
<td>24.3 Family planning consultation (Y/N)</td>
<td></td>
</tr>
<tr>
<td>24.4 Treatment (Y/N)</td>
<td></td>
</tr>
<tr>
<td>24.5 Other, specify:</td>
<td></td>
</tr>
<tr>
<td>BREASTFEEDING</td>
<td></td>
</tr>
<tr>
<td>25. Do you breastfeed your baby (Y/N)</td>
<td>Yes ——&gt; Go to 26</td>
</tr>
<tr>
<td>25.1 If No, have you ever breastfed your baby (Y/N)</td>
<td>No ——&gt; Go to 28</td>
</tr>
<tr>
<td>26. Did you give your baby breastmilk right away after delivery (Y/N)</td>
<td>Yes ——&gt; Go to 27</td>
</tr>
<tr>
<td>26.1 If No, did you give breastmilk within 24 hours (Y/N)</td>
<td></td>
</tr>
<tr>
<td>27. Did you give your baby colostrum? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>28. Did you give your baby any liquid or honey within one or two days after delivery? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>29. Did you give your baby any other liquid or food yesterday? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>FAMILY PLANNING</td>
<td></td>
</tr>
<tr>
<td>30. Are you using family planning method? (Y/N)</td>
<td>Yes ——&gt; Go to 30.1</td>
</tr>
<tr>
<td>30.1 If Yes, what method (coding)</td>
<td></td>
</tr>
<tr>
<td>31. If No, what is the reason (coding)</td>
<td></td>
</tr>
<tr>
<td>Anthropometry</td>
<td></td>
</tr>
<tr>
<td>32.1 Mother’s weight in kg</td>
<td></td>
</tr>
<tr>
<td>32.2 Mother’s upper arm circumference (cm)</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E

Social Marketing Support Materials
Distributed to Project Staff
IMPLEMENTING AN IE&C PROJECT OR COMPONENT

Implementation Steps

Preparing the IE&C plan is a necessary task for securing funding for a project and for guiding implementation. Inputs, outputs, and other elements of the plan should be designed in as much detail and as accurately as possible. Once the project is funded and approved, however, the actual implementation should be as flexible a process as possible, with the manager and technical experts gradually learning through research and testing the most effective strategy, messages, and media to achieve the objectives enumerated in the project plan. On the following page is an overview of the implementation process.
Project Implementation Plan for a Large, Multi-Media Program

Approximate Time in Months

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Formative Research
Analysis
Intervention Test
Strategy Development
Prototype Message Development
Pretest
Message/Materials Revision
Baseline
Final Materials Production
Training
Implementation
Monitoring Studies
Evaluation - repeat baseline

(2-3)
(1-2)
(1-2)
(1-2)
(3-4)
(1-2)
(2-3)
(6-8)
(1-3)
(2-3)

at least every 6 months
after 18-24 months of implementation
The following pages present the detailed implementation steps in a thorough IE&C effort to promote demand for tetanus toxoid (TT) immunizations among fertile-age or pregnant women (the target group would vary depending on national policy). The manager of a particular project may decide to skip or abbreviate one or more steps, but they are all presented as a guide.

**Conduct Formative Research**

Objectives: Plan and complete a qualitative (usually enough quantitative information exists upon which a qualitative study can be structured) study of knowledge, attitudes and practices (KAP) among mothers, health workers, and other relevant groups in order to establish the basis for the message and media strategy and for training and orientation sessions for all program staff and collaborators.

- Develop a research protocol for in-depth interviews and/or focus group discussions (FGDs).
- Develop and pretest question guides for in-depth interviews and/or moderator guides for FGDs.
- Train research personnel.
- Conduct in-depth interviews and/or FGDs.
- Organize/transcribe research responses.

In-depth interviews and FGDs (as well as observational or other studies) may be conducted by a research firm, university faculty and students, or government and NGO personnel, possibly with technical assistance in planning, training, and analysis. In the tetanus example, in-depth interviews would cover different segments of women (unmarried girls 12-16, pregnant mothers, women with and without a TT immunization), local health personnel, and other likely influencers (e.g., husbands and traditional birth attendants). The objective is to obtain a detailed picture of both what mothers do and why they do it, as well as to learn what sources of information most influence mothers. Interviews include detailed questions on: current KAP regarding tetanus and TT; KAP regarding their newborn's health, mothers' feeling of control over their newborn's health, traditional and nontraditional care they would seek; attitudes toward seeking TT if available in various locations and times; authority figures who might lend credibility to messages; and media (information) exposure patterns.

FGDs are an additional manner of understanding current behavior and the potential to change it. These are open-ended, informal discussions among homogenous groups of people. A trained moderator guides the discussion to probe knowledge, attitudes, and perceptions regarding maternal and neonatal health problems and immunizations; to clearly identify blocks (resistance points) to seeking TT (e.g., fear that any injection during pregnancy is dangerous to the baby) and ways (motivations) to overcoming them; and to examine reasons for not having adopted such behaviors in the past. Particularly on sensitive topics, "projective" techniques may be used to facilitate the respondents' "projecting" their own feelings: the group participants discuss what they believe their neighbors or someone in a photograph may feel or think. Discussions are taped, transcribed verbatim, and if necessary, translated. Selected verbatim comments by participants may be incorporated into actual messages.

**Approximate time: 2-3 months**
**Analyze Formative Research**

Objectives: To formulate action-oriented objectives for the distinct audiences and document how basic program decisions emanate from the research.

- Analyze interviews and FGDs (verbatim transcripts).
- Prepare a report that summarizes the formative research findings and their implications for behaviors which will be recommended and likely resistance and motivational statements for each segment of the target audience as well as service enhancement/alteration ideas.
- Review the report with the appropriate authorities.

**Approximate time: 1-2 months**

**Test the Intervention Strategy**

Objectives: For the proposed behavioral changes or alterations in services, assess the feasibility, acceptance, difficulties implied, magnitude of resistances, and mothers' perception of the "goodness" of the change among a sample from each target group segment. In the example of TT immunization where the basic behavior is appropriate service utilization, any modifications in the service (hours, location, health worker orientation) would be part of the test.

- Develop the research protocol, including the precise advice given to each group (when, where, and how to seek TT immunizations).
- Develop and pretest question guides.
- Train research personnel.
- Conduct interviews before and after mothers are asked to actually go for a TT immunization.
- Write a report describing the implications of this research for modifying proposed messages or service delivery procedures.

The basic concept is to ask a small number of mothers from each audience segment to try out the proposed behaviors and to record their initial reactions. The words the investigator uses are carefully formulated to ensure that the person has all of the information s/he needs to take action. The mothers are then revisited to see to what extent they have been able to follow the advice, why, and how they felt about their experience. This research helps define program strategy: to further refine the advice and service components in order to lead to then better acceptance; allocate resources and efforts over various messages (by sensing how difficult each is to promote); uncover further resistance points which the strategy must address; and identify benefits clearly perceived by mothers, which can be used as motivational draws in the messages.

**Approximate time: 1-2 months**
Develop the Strategy

1. **Design Message Strategy and Needed Program Alterations**

Objective: To guide and direct writers, artists, and production personnel who prepare the messages and materials for each target audience segment. The message strategy describes target audience characteristics, desired messages, tone, and additional information that must be included (e.g., where to obtain more information).

The **message strategy** statement explains how messages will achieve their objectives by including effective motivations, resolving resistance points, and presenting essential information clearly. It explains a message's broad theme and incorporates psychological elements, such as use of authority figures or mothers' aspirations for their newborns. The message strategy should be complemented by actions outside of but supportive of IE&C efforts, e.g., changes in legislation, standard clinic practices, or the hours health services are available.

**Message content** must be specific, easy to understand, technically correct, and relevant to resolving the problem. The design approach chosen should persuade people to view an idea from a new perspective and to accommodate a new idea or practice in their daily lives. The **persuasion factors** must appeal to the target audience. Appeals can be emotional or rational. The **memorability factor** is important, since messages need to be remembered and reinforced. Various media should repeat key messages.

Obtaining necessary political and technical approvals for the message strategy is critical for avoiding major problems later in program development. A brief description of the decisions on messages should be circulated widely.

**Approximate time: 1 month**

2. **Develop Media Plan**

Objective: To provide detailed specifications regarding media mix, reach and frequency objectives, time periods, duration of campaign, budget.

- Prepare a detailed media plan.
- Negotiate, with radio stations and other organizations, the arrangements for broadcasting, distributing, and displaying materials.
- Review the plan with appropriate authorities.

The plan should explain (a) the roles of each medium, including mass media such as television, radio and posters and interpersonal media such as local health workers and mothers clubs; (b) how much and what segments of the audience each should reach; and (c) the nature, distribution or frequency of each. The need for developing or obtaining better cooperation from the media should be contemplated (workshops, a piece of equipment, etc.). The plan should cover support materials that will be provided to collaborating sectors, both public and private, to minimize the possibility of
mothers' receiving conflicting messages. A plan for training interpersonal communicators should also be included.

**Approximate time: 1 month, possibly concurrent with previous step**

**Develop Prototype Messages**

Objective: To prepare sample messages for each medium, for subsequent pretesting.

- Produce sample messages for each medium.
- Review the messages with appropriate authorities.

The ad agency (or whoever prepares the messages) should incorporate all necessary factual and psychological elements, while being creative in making them interesting and clear. Unifying phrases, themes, logos, tag lines, and consistent tone should be in all messages. Items developed here might include television or radio spots or programs, flipcharts, pamphlets, posters, product displays, etc. Depending on the requirements of the program, instructional materials for health workers may be required.

**Approximate time: 3-4 months**

**Pretest Messages/Materials**

Objective: To ensure that messages do what they are designed to do, they must be tested to ensure that they are comprehensible, credible, culturally relevant, practical, and that they do not elicit any negative reactions nor dispose the listeners to follow the advice given. The pretest allows designers to understand and be able to correct any shortcomings.

- Design research protocol.
- Develop pretest instruments.
- Train investigators and moderators.
- Conduct pretests.
- Analyze results.

Both in-depth interviews and FGDs can be used. Mothers, influencers (husbands, mothers-in-law, local authorities), and health workers should be all queried.

**Approximate time: 1-2 months**
Revise Messages/Materials

Objective: To fine tune messages and materials in accordance with pretest results.

- Revise messages and materials.
- If major revisions are required, retest messages and materials.
- Review revised messages with appropriate authorities.

Approximate time: 2-3 months

Conduct Baseline Study

Objective: To quantitatively establish the position of the target audience in order to measure exposure to messages and changes in KAP.

- Design the survey instrument.
- Pretest the survey instrument.
- Train interviewers.
- Conduct the survey.
- Analyze the results.
- Write the report.

This survey comes at the end of the preparatory phase of the project for several reasons. Most importantly, it is only after the message strategy and media plans have been completed that the specific project strategy and behavioral objectives are clear, so a baseline survey can thus be designed to provide quantitative data on these areas. Typical areas of inquiry are: knowledge of messages, attitudes towards recommended behavior, implementation of behavior.

Approximate time: 6-8 months (concurrent with previous and following steps)

Produce Final Messages

Objective: To produce the actual materials used in the educational phase.

- Produce materials for direct dissemination through mass media.
- Produce information/educational materials for teachers, health workers, traditional birth attendants, NGO personnel, and anyone else who is communicating the messages.

Approximate time: 1-3 months
Familiarize Relevant Groups with IE&C Activities

Objective: To familiarize all collaborating public and private organizations with the objectives, strategies, and messages of the IE&C activities and of their respective responsibilities in helping ensure their success.

- Schedule training, orientation sessions, meetings.
- Invite participants.
- Conduct meetings.
- Carry out needed follow-up with groups.

This phase can be limited to familiarizing groups with the IE&C activities or it can go beyond this to specific training in the use of the materials and communication skills. Often, it is essential to build the confidence of program staff for the task ahead, to prepare them to become a "sales force," for example, for TT immunization.

Approximate time: 2-3 months (but varies widely depending on the reach of the project)

Implement the IE&C Activities

Objective: To transmit appropriate educational messages through the indicated media in order to achieve the desired behavior changes.

- Plan and carry out a highly publicized project launch event.
- Carry out and supervise the IE&C activities.

While implementing the project, the manager must balance activities conducted by the central office with those conducted by the states, districts, or communities. Even if the activities done on a local level appear less "professional," their contribution may be more valuable as they may be tailored to a specific need or cultural style. This flexibility is crucial.

Time required: the activities should be designed to be sustainable

Implement Monitoring Studies

Objective: To assess periodically the coverage of the educational messages and the audience's awareness and recall of them, so that strategic modifications can be made as needed, e.g. redefine target audience, retraining for health care workers, clarification of available services, etc.

- Design instruments for audience research.
- Conduct research approximately every six months.
• Analyze research.

• Make program modifications.

These studies may be quantitative and/or qualitative in nature. They are usually conducted every six months following launch.

Conduct the Final Evaluation

Objective: To determine the extent to which the campaign achieved its objectives.

• Develop research protocol.

• Train field investigators.

• Conduct field research.

• Analyze results and compare them with those of baseline survey.

• Write report.

This is essentially a repeat of the baseline survey. Along with project monitoring studies, this survey should explain both the success of the project in exposing mothers to the messages and the impact of these messages as measured by the percentage of women immunized and reported cases and rates of neonatal tetanus.

Approximate time: 9 months

The implementation steps described above have the ultimate objective of achieving a program that will change practices, not merely transmit relevant knowledge.

• Program decisions are based on consumer preferences and ways to overcome resistances to change. They all consider program sustainability.

• The solution requires creativity in devising a comprehensive strategy that addresses major constraints through effective communication, often complemented by training, service improvement, policy modification, etc.

• Media are selected on the basis of research that identifies a media mix that maximizes getting specific messages out through media respected by the audiences, to as many people in target groups as often as possible, and at an affordable and sustainable cost.

• Messages are designed to describe specific actions to be taken, resolve resistances convincingly, offer meaningful benefits, and be memorable.

• Communication implementation mixes standardized, centrally run activities with locally developed and managed activities, and in the process of implementation, institutions are strengthened, and
program workers are trained appropriately to believe in program messages and to build their role as educators.

- After the launch of communication activities, they are monitored regularly, and the program is refined based on the monitoring feedback.

Not all IE&C program or components have these desirable characteristics. The following section describes some common pitfalls in IE&C design and implementation.

Problem Areas in IE&C Program Design and Implementation

1. Failure to establish clear IE&C policies and guidelines: National IE&C implementing agencies need to have clear IE&C policies and working guidelines which establish their mandate and responsibilities vis-a-vis other agency operations and program activities. Policies which define the flexibility, the constraints of the modus operandi, and the priorities among available alternatives for the IE&C program are important to good program management and facilitate inter-agency coordination and utilization of resources.

2. Lack of well-defined measurable IE&C program objectives: IE&C programs too often fail to demonstrate adequately to decision makers as well as medical and service staff that they have had the planned impact on program targets. This may be due to the lack of specific IE&C objectives and targets established during the planning stage or to lack of good monitoring and evaluation. The failure to establish a good monitoring and evaluation system for the program is usually linked to not having used experts in evaluation and not having allowed enough money for the evaluation effort.

3. Poor message and media selection: Decision makers often influence an IE&C program by pre-selecting one media, e.g., posters or print materials, over others or determining what the message should be without adequate thought to the relevance of the messages or the choice of media to the target audience or the problem to be addressed. Effective communication requires that message and media be tailored to the needs of the audience and to whatever media they will come in contact with frequently. For example, video productions will probably never be seen by those who need the information, unless they are shown in commercial theatres.

4. Poor coordination and preparedness of the service delivery component: Program implementors may find that the success of health service demand-creation activities, particularly those that direct the target audience to the service-delivery structure, rests largely on the cooperation and preparedness of the service-delivery component. Service-delivery staff are likely to be more cooperative if they are informed and consulted on proposed IE&C activities and more importantly, if their contribution is recognized. Regular communication in both directions is necessary to resolve program implementation problems and issues which may arise.

5. Failure to use appropriate technical assistance: Planners often expect staff in the IE&C program execution agency to be responsible for all program planning, design, and implementation, ignoring the fact that staff resources and expertise may not be adequate to execute all needed tasks. Careful consideration should be given to the need to contract out work which may be more suitably performed by specialized agencies. Similarly, planners need to be sensitive to the proper use of local and international consultant support to facilitate timely and efficient program implementation. Program
Managers who make use of technical expertise in a way which reinforces and provides in-house training and skills development for local staff often find that their projects are well executed and successful.

6. Poor costing of IE&C project activities: Failure to cost out IE&C activities adequately can harm program effectiveness. Budgets need to be prepared for all essential IE&C tasks, including formative research and evaluation activities, materials distribution costs and logistic support for program monitoring, and implementation. A common mistake is failing to appreciate the true financial costs of producing materials because false assumptions are made about the cost-absorptive capacity of various collaborative agencies. For instance, it is assumed that because a national broadcasting station is owned and operated by the government that the "government" project would not be charged broadcasting costs; also, that all materials production and print work would be done without charge through other public sector agencies. A number of governments now insist that agencies under their jurisdiction institute strong cost-recovery programs which mandate that charges be made for services, regardless of the requesting agency. Also, in many cases, in order to achieve the required reach and frequency of radio messages, it is advisable for a project to pay for commercial broadcast time even when free government time is available.

IE&C planners fail to recognize that they can build cost-sharing as well as cost recovery activities into their program plan. In Mexico, for example, pamphlets that were developed, tested, typeset and printed the first time with international funds, were reprinted at a very low cost to be sold to other family planning clinics around Mexico. In Brazil, a family planning group sells materials to federation members at a subsidized price. Cost recovery can work if: a) IE&C products are of good quality and commercially viable, b) buyers and sponsors for the products are actively solicited, and c) a marketing strategy is developed for the proper sale and distribution of products.

7. Failure to educate media professions as well as key decision makers on the program issues being addressed through the project: In one African country, the method of choice by women using modern contraception is the injectable, but owing in large part to unfavorable press, this method was banned by the political leadership. Recently, in response to popular grassroots pressure, the ban was quietly lifted; however, the press was not informed as to the reasons for the reintroduction of the method and for weeks headlines in local newspapers re-created the negative and controversial climate associated with use of the method. The result was the swift resumption of the ban by the political directorate. In Paraguay, a TV spot announcement for a diarrhea campaign was pulled off the air by health officials leaders because they felt the child in the spot looked "too sick." Project implementors had failed to inform the leaders adequately about the campaign and obtain their approval and full support for key outputs. The media and local influencials can become strong allies of those in the health sector if they are treated as key target audiences that also need to have their attitudes and behavior changed.

8. Failure to obtain a good IE&C program manager: Management is an important yet often underestimated factor in an IE&C project. Managing a communications intervention requires decision making capability the level within the organization where important decisions can be taken and implemented, organizational skills, knowledge of staffing, and procurement of services, capabilities in strategic planning, communication, and directing, (leadership). A good IE&C manager does not have to be an expert in research, creative work, media placement, finance or the technical area being supported by the communications staff. These sophisticated skills can be obtained from other IE&C staff or contracted to outside experts or agencies. Too often IE&C staff attempt to act both as
managers and implementors, with management being lost to the technical detail of implementation. The budget for the IE&C component should include resources to support program-management inputs such as staff, finances for program supervision, staff development, technical assistance, and subcontracts.

The key functions of a good IE&C manager are:

- **Resource mobilization** - In addition to knowing how to cost IE&C activities and develop accurate budgets, a good manager should know how to harness the resources of other organizations, agencies, and media to supplement IE&C program budgets.

- **Advocacy** - IE&C managers need to be good advocates of their program and skilled in promoting its strengths and successes at all opportunities. In addition, good diplomatic and negotiating skills may well be required to meld the desires of several diverse technical programs into a coherent communication program.

- **Strategic program planning** - The ability to conduct timely strategic planning exercises based on relevant service and media-related data can save money and effort, as often without a strategic plan opportunities are missed or effort duplicated.

- **Monitoring and evaluation** - The hallmark of a good IE&C manager and management system is the ability to efficiently respond to necessary program changes and service demands. The development of functional monitoring instruments to use to track the performance of project activities and the implementation of evaluation activities are critical exercises that the manager must plan and coordinate.
13. Conduct monitoring research and make necessary program adjustments.

The need for in-service training, more materials, or revised educational messages may be uncovered here. The necessary steps to improve the program are taken at this time.

14. Conduct a final program evaluation.

The type and method of evaluation will depend on the program’s objectives and resources. In all cases, however, regional or national seminars should be held to discuss the program experience and offer recommendations for future activities.

c. Social Marketing to Improve Maternal and Neonatal Health and Nutrition

Programs to improve maternal and neonatal health and nutrition may elect one or more of the following strategies to achieve their aims:

- Teach and motivate women and families to make small changes in their behavior that will enhance the health of women and their newborns. The basic desirable behaviors are listed in Figure 8. In particular programs, they will be very specific for specific groups of mothers and families.

- Offer simple and effective preventive and curative services, provided at the appropriate levels of the health system (primary, secondary, tertiary), using the principles of risk-detection.

- Improve women’s social, economic, educational, and legal status.

Social marketing can provide critical support to implement each of these strategies successfully. It can be used to:

- design creative, effective communications and public education programs that will achieve behavioral changes to improve maternal and neonatal health;

- reveal the most acceptable health services and suggest changes in services that will make them much more attractive to women;
Encouraging people to change their behavior requires a complete and thorough knowledge of existing practices. We can neither presume what these may be, nor in what way a mother (or anyone else) can be persuaded to adopt them. To develop effective communication programs, program managers must gain a clear grasp of present attitudes and practices and of feasible behavioral changes through in-depth discussions with the people whose behavior they wish to change. Then, by working with them until they are completely confident that they can put the proposed actions into practice, program managers can accomplish the task of understanding how to produce messages that are feasible to follow, believable, culturally relevant, and entirely convincing—messages that will accomplish the practical goals of the interventions.

Programs receiving social marketing communications support will proceed according to the basic steps outlined earlier.

d. Program examples

In the Integrated Child Development Scheme (ICDS) being carried out by JSI and Hanoff, International in India, program officials learned the following from social marketing research:

- Whether they should fulfill pregnant women’s caloric shortfall through urging them to eat more of their regular food or to add a nutritious but easily made snack to their diet. In behavioral trials, women would not make the suggested special snack, so recipes and motivational appeals were developed and tested.

- Whether iron and folate needs of pregnant mothers should be met through pill distribution or through dietary change. Research showed that pills were the best choice. Education specifically aimed at improving iron consumption was not undertaken.

- Whether food rich in vitamin A-rich food should be promoted for pregnant women. In the face of an apparent serious availability problem that could not be solved in the short-term, the program decided not to initiate the promotion of these foods.

With respect to identifying actual feeding practices, resistances and motivations to change, formative researchers who were interested in promoting colostrum learned:

- Practices: breast-feeding is never started on the day the child is born but usually a few days later; before the child is given breast milk, s/he is fed with "jaggery" water with a cotton ball or "gathuthi" (sometimes diluted with goat’s or cow’s milk); colostrum practices vary substantially, with half of mothers not given any; otherwise, breast-feeding practices are satisfactory.
**Resistances:** Mothers delay starting because of beliefs that the child is too young to suck/receive breast milk or that s/he does not "get breast milk" for the first few days; mothers reject colostrum because it spoils the child's stomach/health and/or is considered spoiled or dirty; elders discourage feeding colostrum. None of these resistances is uniform or extremely strong.

**Motivating factors:** The very positive feeling towards breast milk might be extended to colostrum; this positive perception might also motivate early initiation; women who do give colostrum note no ill effects.

Researchers also examined women's roles and sense of self-confidence to understand how they affect behavior and would influence behavior change. They learned:

- Mothers feel their role is to serve their husbands, mothers-in-law, and children. They make no decisions since their mothers-in-law are powerful and their husbands control all of the money.

- Mothers feel they are not worthy of going out from home for any activity except agricultural labor.

- Mothers recognize that they can and should breast-feed their children, but universally they feel helpless to ensure good care for their children in the presence of constraints such as lack of money, lack of facilities, and circumstances dictated by God.

These and other findings led to the following decisions for the educational program:

- A part of the program should be directed to fathers and mothers-in-law since the social environment is not conducive to independent actions by women in the area of health and child care.

- A weekly radio soap opera dedicated to raising women's self-confidence would be developed. The program can be listened to at home, but mothers are encouraged to gather at child care centers, where there is an opportunity for discussion following the show.
factors. Selected survey findings might be further probed through qualitative methods.

**Systematically Addressing Low Acceptability**

In many countries, there has been extensive communication support of immunization goals, particularly in conjunction with UNICEF-assisted accelerated immunization activities. 'Social mobilization' -- public communication, advocacy, and coalition-building efforts -- has aimed, and frequently achieved in the short-run, to stimulate enthusiasm for immunization among the public and support for immunization services among public and private groups not traditionally involved. Messages, materials, and strategies have infrequently been based on qualitative research among mothers and others, and have often been aimed at essentially a one-time behavior -- bring your child for immunization on a particular day.

Social marketing, a systematic approach to achieving beneficial behavior change, has been used fairly extensively in developing countries to promote contraceptive use and improved child nutrition practices but rarely for immunization. Promoting immunization is an interesting challenge. On the one hand, the basic behavior being promoted is simple -- bring your child to be immunized; but on the other hand, it is a behavior that must be repeated at intervals of a month or more and to which there may be a number of powerful resistances. While achieving a high one-time turnout for an immunization day may be relatively easy, even among populations not used to taking modern preventive health measures, socializing the concept of complete childhood immunization, so that parents bring in all of their infants for immunization as a normal action, is clearly more difficult.

For improving the quality and effectiveness of immunization services, the systematic approach of social marketing can assist in achieving the following general behaviors:

- for mothers/caretakers, to bring their children of the appropriate age to the correct place at the correct time for their immunizations; for DPT and polio, to bring back their children for the full series; to expect and appropriately manage mild side effects.

- for health workers, to treat mothers/guardians and children with respect; give mothers/guardians essential information regarding when to return and side effects; give mothers/guardians an opportunity to ask questions, express concerns; take advantage of all practical opportunities to immunize; maintain the cold chain; use sterile techniques.

Borrowing techniques from both the social sciences and commercial marketing, social marketing advocates the use of a systems approach -- a logical series of steps -- to define social problems and to develop and implement behavior-oriented solutions. For immunization, it should be able to facilitate both modifying immunization services to make them more acceptable (improving the product) and helps in designing effective
communication of the factual and motivational information that will lead to more parents bringing their children for immunizations (stimulating demand). Several important characteristics distinguish social marketing from other approaches to health education and/or health improvement.

Social marketing hinges on community participation in decision-making. Formative (program design) research is used to understand the problems and practices in the cultural and social setting of the persons involved (mothers and people who influence them, as well as health workers). Decisions regarding the specific behavioral changes desired, messages, media, and materials are determined through a long and varied dialogue with the persons involved, not predetermined by health professionals. Involving the public in this way reduces the chance of undertaking inappropriate and ineffective health improvement activities.

The objective of social marketing is to change behavior. While traditional health education focuses on changes in knowledge regarding health matters -- usually defined from the health professional's point of view -- social marketing communication focuses on changes in concrete practices. For example, a conventional health education message may say, 'come to the health post to immunize your child. This will save your child from many serious diseases.' The result is that although mothers may understand the message, many do not bring their children because they have not been sufficiently motivated and assisted in overcoming their many concerns and fears, time constraints, etc.

In social marketing, formative research provides the background for developing a comprehensive strategy for behavior change. The research allows planners to consider all viable behavioral options for tackling priority problems before singling out key activities for attention. The resulting strategy carefully segments target audiences to insure that the right messages are being delivered to the right people at the right time. This stands in contrast to most health education messages -- which are too general to motivate immediate action, which do not contain effective and creative motivations, and which are not easily 'doable' for many people.

Social marketing adopts commercial marketing's techniques for appealing to consumers by carefully researching the life-style, aspirations, and hopes of targeted beneficiaries in order to convert these into effective appeals. As in commercial marketing and advertising, research findings are translated into creative intervention strategies that constitute a fresh approach to motivating behavior change. For this reason, for example, a social marketing effort in Indonesia to combat vitamin A deficiency was designed as a promotion of green leafy vegetables. The appeal was the vegetables health-giving vitamins, not their specific ability to prevent xerophthalmia. In encouraging mothers to feed their children more green leafy vegetables, the messages addressed such resistances. For example, a doctor stated that infants can easily digest the vegetables, particularly if they are finely chopped.

The major appeal of immunization communications might be, if indicated by formative research, that all good parents have their children completely immunized against a number of dangerous diseases. Mass media messages may or may not name all the specific diseases and immunizations (person-to-
person communications might well be responsible for providing such essential information as what child needs what immunization, when, and where. Messages in a successful communication campaign in Metro Manila used fear of measles as a 'hook' to motivate parents to bring their children for all EPI immunizations (Cabanera-Verzosa).

Social marketing addresses both the supply and demand side of problems. The protection afforded by immunization may only be obtained through parents/caretakers bringing children to receive a health service. A major reason for non-acceptance of immunization is dissatisfaction with previous immunization or other health service experience, because of problems with service convenience, organization, or attractiveness. Social marketing research examines these areas of concern from both the users' and providers' perspectives. The process yields suggestions both for making services more attractive and for promoting them more effectively.

### Distinctions Social Marketing and Health Education

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<thead>
<tr>
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<th>Social Marketing</th>
<th>Health Education</th>
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<tbody>
<tr>
<td>De facto objective</td>
<td>to change behavior</td>
<td>to increase knowledge (which is assumed to lead to behavior change)</td>
</tr>
<tr>
<td>Planning</td>
<td>jointly with public and health workers</td>
<td>top down</td>
</tr>
<tr>
<td>Strategy</td>
<td>creative</td>
<td>straight-forward</td>
</tr>
<tr>
<td>Message content</td>
<td>motivational and logistical information</td>
<td>factual information</td>
</tr>
<tr>
<td>Message specificity</td>
<td>specific messages for each target subgroup</td>
<td>usually quite general</td>
</tr>
<tr>
<td>Resistances</td>
<td>messages either debunk or give practical ways of overcoming</td>
<td>not systematically studied or addressed</td>
</tr>
<tr>
<td>Media</td>
<td>always mixed, selected on basis of research</td>
<td>usually selected by health professionals alone</td>
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The basic steps in a social marketing process, adapted for immunization, are described in Appendix 2.

### Lessons Learned by REACH and Others

A number of issues in immunization communications have been touched
Appendix B

Steps in Social Marketing of Immunization

1. Conduct formative (planning) research.

Problems and existing attitudes, perceptions, and practices are studied using qualitative techniques such as focus group discussions, in-depth interviews with health workers and parents, and observation of immunization sessions. The research uncovers cultural, psychological, economic, or logistical resistances (barriers) to the preferred behaviors as well as helpful attitudes and practices that can be used to overcome resistances. Mothers and persons likely to influence them (possibly fathers, mothers-in-law) as well as health workers and other potential carriers of immunization messages would be consulted in this phase.

The initial research is likely to uncover such barriers as confusion regarding the purpose of immunization; difficult accessibility because of time, cost, or convenience; poor or incorrect information regarding which children and women need immunizations and when and where they should go for them; fear of side effects; mistrust of or unpleasant experiences with the health system. The formative research should reveal both the strength of these resistances and insights into how they might be overcome through communication and/or through modifications in services. Research should also uncover potential motivating appeals to mothers, where mothers get their information, their trust in different sources of information, whom they seek advice from in the community, etc.

2. Identify a series of behavioral changes based on formative research findings that are likely to result in improved immunization coverage.

Systematic analysis of the formative research leads to the identification of problems and the resources needed and available to alleviate them. In the case of immunization, the likely behavioral changes for mothers would be: bring your children, both healthy and sick ones, at the appropriate times and places for immunizations; expect and do not be upset by mild side effects; get full protection with TT for yourself and your newborns. For health workers, the likely behavioral changes would be: always maintain the cold chain and use only sterilized needles; do not miss opportunities to immunize; give mothers adequate and understandable information on reasons for immunizations, expected side effects, the need, time, and place to return for additional immunizations; and treat mothers with respect.

3. Test the priority changes with a small group of beneficiaries and program implementors.

Because of the long-term, repetitious nature of the desired behaviors, there is no practical way to quickly test the full course of the desired behavior (mothers bringing their children for the full series of immunizations). However, a pilot test of the communication to parents/guardians and of modifications in immunization services in each major geographical/cultural area could be done.
4. Design an intervention strategy to overcome resistances to adopting new behaviors.

The intervention strategy would normally contain three major components: communication, training, and service-delivery improvements. The communication strategy defines the specific behavior changes that will be promoted in different geographical areas and among different target/consumer groups (e.g., mothers of infants 12-23 months old who have no immunizations, who have some but not all basic immunizations, and who have completed the basic series of immunizations; and either pregnant women or all women of child-bearing age, depending on the II target group). It describes the creative approach for overcoming problems and resistances to change, detailing what appeals and motivations will be used for each target subgroup. It also includes plans for gaining the support of husbands and others likely to encourage or inhibit mothers’ new behavior (WHO/EPI, March 1989).

An essential aspect of the creative strategy that will emerge from the formative research is how much information about the target diseases is necessary to motivate mothers to bring their children. Should the diseases and their symptoms be specifically mentioned? (Formative research is likely to show that some of the diseases are known fairly specifically but that others are not known or are considered part of a broader syndrome of disease.) Should immunizations be promoted as a special preventive injection, just as people get vitamin injections? Should doctors or mothers-in-law be used in messages to negate resistances? Only local research can answer such questions.

The training component supports the communication strategy. What people need what training, when and how, to fulfill their roles as communicators or reinforcers of important information? Additionally, what retraining do health workers need in order to overcome problems in their performance perceived by the public? There should also be plans to convince and train influential community or local government officials to promote immunization.

The service-improvement component includes recommendations for modifying service hours, locations, or organization that research show to be important for making services more acceptable. It gives plans for better supporting health workers so they will treat the public more supportively and competently. It might also outline new incentives that the health services could institute to motivate performance from health workers.

Since the long-term objective is to socialize the basic concept of immunization, the strategy should include plans for working through such community institutions as schools, mothers clubs, and not least of all, the health centers and health posts to encourage immunizations on an ongoing basis. Some rapid social mobilizations for national immunization days have not sufficiently incorporated the regular health system for promotion and immunizations, a major mistake in terms of long-term EPI sustainability.

5. Develop an implementation plan for the strategy.
This operational plan details all the technical inputs and resources required to execute the intervention strategy. For education and communications interventions, it also describes the details on media production, distribution, and use, and the numbers and types of people to be trained and supervised (where, how, when). This strategy is based on information gathered during formative research with the public and health workers. The interventions should be implemented on an empirical seasonal schedule so that the timing and content of communications take into account the peak risk of the health problem and/or with service pulses (in the case of immunization days).

6. Pretest and revise all messages and materials.

   Educational and promotional messages and materials are designed and circulated for feedback among program staff and key policy/decision-makers. Pretesting among the target audience subgroups is usually done using in-depth interviews and/or focused group discussions. After revision, all education and promotional materials should be approved by the appropriate authorities prior to finalization and production.

7. Produce all materials and confirm the acquisition of all supplies.

   Ample time should be left for this activity to avoid unnecessary and costly delays that may arise in the production process.

8. Design a program monitoring and evaluation plan.

   Program monitoring and supervision should be designed to answer questions about how the program is operating, whether it is having its anticipated effect, and what adjustments need to be made. Monitoring and supervision information should feed right into program operations to ensure that it is working effectively. Monitoring will discover: are communication activities being implemented as planned, are the target audiences receiving and understanding the messages, are the messages successfully motivating them to action, and are they acting?

   Evaluation, on the other hand, is usually focused toward measuring the impact of the intervention strategy. In the case of immunization, the impact of the program on coverage, on dropout rates, and on the percentage of one-year-olds who are fully immunized are examples of useful indicators of project impact. It may or may not be feasible to design evaluation to distinguish among the separate contributions of the major components of the social marketing plan (training, service improvement, service promotion).

9. Launch the intervention effort.

   Materials and supplies are distributed. Required personnel are trained in how to implement the intervention strategy (to carry out specific procedures and use communication materials, for example). It is likely that one of the materials will be a set of 'counseling cards' to assist local health workers transmit essential information to mothers.
Careful attention to management of project communications is essential. The best messages and media plan in the world will have little effect if health workers who are supposed to talk to mothers are not well trained and supported, if radio spots are not broadcast as planned, or if posters are not posted as planned. Likewise, good management is essential to the supply side of the equation. Unsatisfactory services, e.g., a lack of drugs or vaccine, can quickly negate effective demand-building.

10. Conduct monitoring studies and make necessary program adjustments.

The need for inservice training, more materials, or revised educational messages may be uncovered here. The necessary steps to improve the program are taken at this time.

11. Evaluate the program.

After at least a year of full program operation, program impact is evaluated either through already-available coverage or survey data or through a follow-up survey.

If the social marketing effort has received extensive external technical assistance, institutionalization and building local capabilities should take place throughout program implementation. Training and project seminars should be conducted at several points in the process, both in order to leave behind trained individuals and groups and to help maintain an understanding and awareness of the project at the policy level.
APPENDIX F

Social Marketing Workplan and Budget
TANJUNGSARI PROJECT
### SOCIAL MARKETING WORK PLAN (TANJUNGSARI)

<table>
<thead>
<tr>
<th>STEP</th>
<th>TIME REQ'D/ DATES</th>
<th>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18/33</th>
<th>Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DEVELOP SOCIAL MARKETING PLAN</td>
<td>1 week 01/91 (pre-project)</td>
<td></td>
<td>RP</td>
</tr>
<tr>
<td></td>
<td>Objectives, Strategies, Resources, Budget, Time frame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CONDUCT FORMATIVE RESEARCH</td>
<td>8 weeks</td>
<td>x x</td>
<td>MM</td>
</tr>
<tr>
<td></td>
<td>Develop qualitative research plan - protocols &amp; instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop scope of work for local consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Select consultant, brief</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Train staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pretest interview guides</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct research</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Translate &amp; organize results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. ANALYZE RESULTS &amp; WRITE REPORT AND STRATEGY WORKSHOP</td>
<td>4 weeks</td>
<td>x</td>
<td>Roharjo Lukman? Consultant and team</td>
</tr>
<tr>
<td>4. TEST INTERVENTION STRATEGY</td>
<td>4 weeks</td>
<td>x</td>
<td>RP</td>
</tr>
<tr>
<td></td>
<td>Develop draft advice/messages</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop &amp; pretest question guides,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Train staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct interviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Write report suggesting acceptability/modifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. DESIGN COMMUNICATION PLAN</td>
<td>4 weeks</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Define target audiences, messages, channels</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Produce creative and media brief</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appoint creative and media team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. DEVELOP DRAFT MESSAGES AND MATERIALS FOR EACH MEDIA</td>
<td>4 weeks</td>
<td>x</td>
<td>RP</td>
</tr>
</tbody>
</table>
## SOCIAL MARKETING WORK PLAN (TANJUNGSARI)

<table>
<thead>
<tr>
<th>STEP</th>
<th>TIME REQ'D/DATES</th>
<th>TECHNICAL ASSISTANCE</th>
</tr>
</thead>
</table>
| 7.   | **PRETEST MESSAGES AND MATERIALS**  
- Design pretest protocol and instruments  
- Train staff  
- Conduct pretest  
- Analyze results  
| 4 weeks | x | | RP |
| 8.   | **REVISE MESSAGES**  
| 3 weeks | x | | |
| 9.   | **PRODUCE FINAL MATERIALS/AND FINAL MEDIA PLAN**  
| | | | |
| 10.  | **TRAIN USERS OF MATERIALS**  
| 2 weeks | x | | CDW |
| 11.  | **LAUNCH (IMPLEMENTATION)**  
| | x | | |
| 12.  | **MONITOR ------->EVALUATE**  
| Ongoing | x x x x x x x x x x x x x | | |


**Proposed Budget (Local Costs) of Social Marketing Component Tanjungsari**

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Rupiah</th>
<th>US $</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Formative Research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local consultant to oversee research (2 months)</td>
<td>9,500,000</td>
<td>5,000.00</td>
</tr>
<tr>
<td>• Local transport/interviewer per diem</td>
<td>300,000</td>
<td>158.00</td>
</tr>
<tr>
<td>2. Concept testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local consultant (1 month)</td>
<td>3,800,000</td>
<td>2,000.00</td>
</tr>
<tr>
<td>• Local transport/per diem</td>
<td>300,000</td>
<td>158.00</td>
</tr>
<tr>
<td>3. Strategy workshop (in Bangdung)</td>
<td>2,000,000</td>
<td>1,053.00</td>
</tr>
<tr>
<td>4. Communication Materials ILLUSTRATIVE - MATERIALS DETERMINED AFTER RESEARCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Production</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 dukun bayi 600 copies</td>
<td>2,500,000</td>
<td>1,316.00</td>
</tr>
<tr>
<td>500 kaders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other print materials</td>
<td>2,500,000</td>
<td>1,316.00</td>
</tr>
<tr>
<td>Radio spots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/day x 9 months (270 days)</td>
<td>10,800,000</td>
<td>5,684.00</td>
</tr>
<tr>
<td>2 stations 20,000/spot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Design of print materials</td>
<td>975,000</td>
<td>500.00</td>
</tr>
<tr>
<td>• Radio scripts</td>
<td>975,000</td>
<td>500.00</td>
</tr>
<tr>
<td>5. Pretest materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>local costs</td>
<td>800,000</td>
<td>421.00</td>
</tr>
<tr>
<td>consultant</td>
<td>3,800,000</td>
<td>2,000.00</td>
</tr>
<tr>
<td>6. Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>600 kader and dukun bayi x 5,000</td>
<td>3,000,000</td>
<td>1,579.00</td>
</tr>
<tr>
<td>7. Field Monitoring (2)</td>
<td>2,000,000</td>
<td>1,052.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>45,250,000</td>
<td>22,737.00</td>
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</tbody>
</table>