Saving New-born Lives

SBCC Plan Malawi

1.0 Situation Analysis

1.1 Background

In Malawi, three conditions—complications of preterm birth, severe infection, and intrapartum-related (birth asphyxia)—account for 89% of all newborn mortality. Complications from preterm birth alone claim roughly a third of all newborn deaths. With the highest rate of preterm births on the globe, preterm birth in Malawi occurs in up to 20% of all births in some districts and low birth weight in 14% of births in the country. Contributing factors to pre-term death are biological, behavioral and cultural and include:

- Low socio-economic status
- Low literacy levels
- Limited decision-making power among women
- Limited knowledge of the danger signs in pregnancy
- Delay in decision making to deliver at a clinic
- Cultural beliefs and norms, including those lead to harmful practices and devalue newborn lives
- Poor infection prevention practices at hospitals and at home
- Previous negative experiences at health clinics/unfriendly attitudes of health care providers
- Distance to health facility
- Availability of transport and transport costs
- Availability, accessibility and quality of newborn care services
- Lack of male involvement
- Lack of value placed on newborn life

Prior to the late 1980s, low birth weight (LBW) babies were nursed away from mothers in locally made incubators, a wooden box with a light bulb below the mattress for heat. When modern incubators were introduced in the 1990s, the supply was inadequate and power outages, lack of manpower, overuse, and maintenance posed challenges. Kangaroo Mother Care (KMC), care of preterm infants carried skin-to-skin, was then developed by Rey and Martinez in Bogotá, Colombia as an alternative to inadequate and insufficient incubator care. It was first introduced in Malawi at Bwaila hospital in the early 1990s by one pediatrician. In 1999, KMC was reintroduced at Zomba Central hospital due to overcrowding in the nursery and the high number of neonatal deaths. KMC has been scaled up across the country since its first introduction in Zomba Central Hospital. As of August 2011, KMC was reported to be available at 121 hospitals in the country. Hospitals in Malawi have been directed to create a designated KMC ward or space by government policy. KMC is normally initiated in the hospital and should continue at home with follow up visits to the hospital until the baby reaches 40 weeks corrected gestational age. This continuity of care from hospital to home is critical for the survival of LBW babies. Almost two decades of implementation and research have demonstrated that KMC goes well beyond incubator care. It is effective for thermal control, breastfeeding and bonding in all newborn infants.

1.2 Prior & Current SBCC/Demand Generation efforts

Promoting maternal child health is not new in Malawi, although most previous efforts have focused on child survival; i.e. targeting caregivers of children under age 5 and promoting EPI, CDD/ORS, and ARI.

According to the Ministry of Health (MOH) Health Education Unit (HEU), prior campaigns with the highest level of recall seem to be those related to HIV prevention. Those campaigns included a PMTCT component, targeting the SNL primary target audience of pregnant women. No evaluation of previous campaigns was found.

In 2011, USAID Malawi awarded the five year Support for Service Delivery Integration (SSDI) Project, consisting of three separate, but interrelated Cooperative Agreements: SSDI-Services, SSDI-Systems and SSDI -Communication. SSDI Communication works with government to support social and behavior change communication (SBCC). Currently the most well-recognized national campaign promoting 6 of the areas covered in the national essential health package, SSDI Communication includes maternal child health in their national "Life is Precious (*Moyo ndi Mpamba*), Take care of it *(Usamalireni)"* campaign. The campaign focuses on life stages and segments the primary target audience into 4 segments: young married couples, parents of children under 5, adolescents, and parents of older children. "Life is Precious" promotes services and behaviors relevant to SNL's mission of saving newborn lives, including the recognition of warning signs during pregnancy, facility birth, and ANC (at least 4 times before delivery and once within the first 3 months of pregnancy.) Also among key campaign messages is that men and women should work together to ensure safe pregnancy and safe delivery. SSDI is also building health worker capacity in interpersonal communication (IPC) to improve provider-client interactions as well as provide health workers with job aids to help them provide quality services. SSDI is also facilitating the formation of traditional ruler's health committees at zonal, district and community levels. These committees meet regularly to discuss health issues and make pronouncements that support healthy behaviors in their communities.

1.3 Gap Analysis

Although there have been and still are multiple BCC efforts to reach women of reproductive age, pregnant women, and caregivers, including the current "Life is Precious" campaign, there has not been a major focus on pregnant women at risk for pre-term birth nor women who have given birth to a premature infant. In addition, despite the fact that health worker capacity building in interpersonal communication (IPC) is under way, there is no link between health workers and the 'Life is Precious' brand; i.e. they are not identified as 'Life is Precious' campaign messengers. Moreover, there have been no efforts to date to address misperceptions and stigma against preterm birth or small/LBW newborns and increase the value of newborn life

1.4 Campaign Context

HEU, RHD and other stakeholders agreed to select pilot districts for the intervention based on the following criteria: .

- A high birth volume district
- A district with well-established KMC services to ensure that there is quality supply to meet increased demand.
- A district with community based MNH interventions currently being implemented.
- At least one district with SSDI interventions and other partner support for KMC services. SSDI coverage was deemed necessary as the newborn health campaign will build on the existing Moyo ndi Mpamba campaign that is being implemented by SSDI.

Based on the above criteria, **Machinga and Thyolo** were selected for pilot districts. Machinga and Thyolo are both in the Southern region of Malawi. Both have district hospitals with well-established KMC units. There are however distinct differences between the two districts in terms of religion and

cultures. The Yao tribe, a large proportion of whom belong to the Muslim religion, dominates Machinga. In contrast, Thyolo is dominated by the Lomwe tribe, the majority of whom belong to the Christian religion. Polygamy is more common in Machinga than Thyolo.

2.0 Target Audience Identification, Profile, and Segmentation

Following is a description of the primary target audience as well as the people who influence them, also known as the secondary target audience. In addition, included below are target audience profiles that put a face on the target audience and a segmentation strategy to insure that SBCC efforts are targeted with a better chance of producing results.

2.1 Primary target audience

The primary target audience is pregnant women and mothers who have just given birth to a low birth weight (LBW) baby. As not all pregnant are thinking about preterm delivery or giving birth to LBW babies, we have segmented the target audience based upon the Stages of Change or transtheoretical model (Prochaska & DiClemente, 1977). In this behavior change model, change is recognized as a process involving progress through a series of stages:

- Pre-contemplation (Not ready)
- Contemplation (Getting ready)
- Preparation (Ready)
- Action (Adopting behavior)
- Maintenance (Maintaining behavior)

Note how the following segmentation strategy builds upon this model

PREGNANT WOMEN

PRE-CONTEMPLATORS: This group reflects one of the segments being targeted currently by the *Moyo ndi Mpamba* campaign in their life stages approach. They are young married women who are currently pregnant or planning a pregnancy in the near future. They are currently not thinking about (contemplating) a pre-term delivery nor caring for a pre-term low birth weight baby. They are living in the pilot districts. Most of them already know the importance of ANC visits due to previous and current health education campaigns, although they may only be accessing ANC late in their pregnancy due to living in remote locations or other obstacles. They live in a rural area in where only basic health care services are provided, yet they hope to deliver in a facility. We may find them in a maternal waiting home as they get closer to delivery.

CONTEMPLATORS: This group of women cuts across the *Moyo ndi Mpamba* campaign segments. They may currently be pregnant or planning a pregnancy and have already had a preterm delivery in the past, putting them at increased risk for having another. They are most likely contemplating the possibility of another pre-term birth, making the information to be disseminated by this intervention even more relevant. Reaching them will prove challenging through mass media, but can be accomplished through interpersonal communication (IPC) with nurse midwives, HSAs, and other community volunteers. To the extent possible, women with predisposing factors for pre-term birth will be identified and targeted, including pregnant women with UTIs/STIs, hypertension,

anemia (poor nutrition), malaria, those living with HIV, and women who have experienced multiple pregnancies resulting in twins and triplets

MOTHERS WHO HAVE JUST GIVEN BIRTH TO LBW BABIES

DETERMINED/PREPARING & TAKING ACTION: This woman has just given birth to a LBW newborn and is in a KMC unit. Most likely one of her family members is with her. She is determined and preparing to practice KMC on her small new baby and the nurse midwife/patient attendant help her to take action.

MAINTENANCE: This group of women have been discharged from the KMC unit and now face multiple obstacles for practicing continuous KMC. Maintenance will be a challenge at home and she could easily relapse due to competing priorities, stigma, and lack of support.

2.2. Primary Target Audience Profile

ANNE MARIA

Anne Maria, a 21 year old woman married to her carpenter husband Elvis, is pregnant with their first child. But this is not her first pregnancy. When she was 17 years old living in a remote village in the southern region of Malawi. Maria fell pregnant during her sexual debut with a 45-year old business man in her village. Being the relatively young lady that she was, Maria did not know the importance of going to the hospital during her first trimester. The young Maria lived with her pregnancy until the seventh month when she delivered her baby boy prematurely weighing 800 grams. She had never heard about KMC and feared that the community would blame her preterm delivery and LBW baby on adultery. Ignorance coupled with childishness compelled Maria to abandon the KMC Unit where medical personnel were able to check on her baby. Sadly, the poor baby died back in the village and Maria and her community believed it was witchcraft. Although Maria has started going for ANC visits, she worries about having another pre-term birth.

2.3 Secondary target audience

The secondary target audience are the people who influence the behavior of the primary audience. They include individuals to whom the primary audience talks about health, those who influence their beliefs and/or actions, and those who provide information, products, and services. This target audience can be described in three (3) categories. In addition, the provider target audience will be segmented between facility-based and community-based.

PROVIDERS

- Nurse Midwives (at the front lines of preterm deliveries and responsible for early initiation of KMC)
- Clinicians (doctors & clinical officers)
- HSAs (to support community KMC/early discharge for stable newborns with follow-up care at home)
- Community Midwives

FAMILY

- Husbands
- Mother-in-Laws

- Other family members of the primary audience

COMMUNITY

These other members of the secondary target audience will form part of a larger group of campaign 'messengers' targeted through messenger training activities.

- Community (health)volunteers, including Lead Mothers
- Religious Leaders (Pastors & Imams)
- Community leaders, including group village headmen
- Care Group members
- Community Action Groups
- Community Mobilization Team (CMT) members
- Agogos (Elders/grandparents)
- Former('veteran') KMC mothers (mentors)
- Local media officials

NOTE: Please refer to the Provider Creative Brief for information on the tertiary audience.

2.4 Secondary Target Audience Profile (Nurse Midwife)

The following profile describes a typical member of the secondary target audience, capturing details like age, marital status, current behavior, barriers to the desired behavior, and beliefs.

NDAZIONA

Ndaziona Chata, single and 28 years old, is a registered nurse midwife with a Bachelor's degree in nursing and midwifery. She lives in a southern district and works at the district hospital on straight shifts. Ndaziona has a very good working relationship with colleagues as well as clients. She has been working in maternity for the past 5 years and is currently in charge of the maternity department that includes the KMC unit. Due to a shortage of midwives there are no allocated skilled staff in this unit; therefore the hospital uses unskilled birth attendants. Ndaziona has oriented this cadre in KMC using information from the obstetric guidelines and protocols to transfer skills to them. They look up to her as their mentor. Most important to Ndaziona is the survival of preterm babies especially those weighing less than 1500gm at birth. Comfortable communicating with her peers, she is not as confident in her ability to communicate about KMC with patients and their families. She would also like to change the attitude of her fellow nurse midwives who do not like working directly with clients, especially preterm babies; however she faces an unsupportive environment as most of her supervisors regard her as someone who should be in the office.

3.0 Research Findings: Audience Analysis & Competition

The SSDI Communication Project conducted a baseline survey and formative research in 2012. The objective of the survey was to establish the baseline benchmarks and inform project interventions. The formative research aimed at understanding the individual, collective, social and structural factors that inhibit or promote healthy practices in Malawi. It was conducted in one district in each zone except Central West zone. It was found that among the women who

gave birth in the past five years, 98% received some antenatal care; childbirth was attend by a trained medical professional - midwife or nurse, a medical assistant or clinical officer or by a doctor (in that order.) In addition, over 80% of births took place in a hospital or health facility.

A qualitative study was conducted from October 2012 through January 2013 to explore the perceived causes of preterm birth, care practices for preterm newborn babies, and challenges associated with preterm birth among community members in Mangochi District. Participants had limited knowledge of the causes of preterm birth, citing young and old maternal age, heredity, sexual impurity, and maternal illness during pregnancy. In terms of care, keeping preterm newborns warm was the most common response reported. Participants also reported challenges to care including lack of knowledge of preterm newborn care, poverty, lack of time due to household and other chores. (Gondwe et al. BMC Pregnancy and Childbirth 2014)

Violet Manjanja, lecturer in MCH at Kamuzu College of Nursing describes women's experiences providing KMC at home after discharge from Bwaila Hospital. A study conducted by Manjanja revealed several harmful practices in urban slums and a few rural areas of Lilongwe that were dangerous to LBW babies, mostly due to traditions of small newborn care and poverty. Most participants practiced intermittent KMC after discharge only putting their babies in KMC position during the night due to house hold chores. Some participants generated warmth for their babies by covering and wrapping them in many clothes and left them inside the house during the day as they were busy with household chores. Other few participants lit charcoal stoves and put inside the house to generate warmth and they slept together with their neonates without keeping them in KMC position during the night. Other participants collected maize husks into a sack bag, placed it beside the baby who was wrapped and laid on a mat. One participant dug a small squared flat hole and prepared a nest like bed with ground nuts covers. The baby was wrapped with clothes and put inside the hole. The few participants who kept their newborns on KMC continuously had a good family support system. Mother's reported feelings about providing KMC at home included anxiety, inadequacy, tiredness, and discomfort. Other challenges included lack of hygiene in small homes with shared toilets, financial constraints, and stigma, with most participants reported of negative comments on the appearance of their LBW baby. Some participants complained that when they carried the babies on their chests, people in the communities called their babies ‘kagaru’ (small dog) which they found offensive.

"People nicknamed my baby as 'Kagaru' meaning a small dog, that pains me a lot, that was when I was walking in the village with my baby while in KMC position."

A qualitative study conducted in Lilongwe regarding knowledge and attitudes on preterm birth (Levison et al. BMC Pregnancy and Childbirth 2014) showed that:

Definitions of preterm birth or “born too soon” varied widely among interviewees: “six months” and “less than one kilogram” were considered at low chance for survival by most participants. Normal estimated gestational weight at 28 weeks or six months ranged from one kilogram to 2.3 kilograms.

Perceived causes of preterm birth (PTB) were consistent among the three groups (couples, community health workers, and clinicians) and included domestic violence, overwork, maternal

illness, sexually transmitted diseases, and young age. Clinicians tended to also include multiple pregnancies and short interval between pregnancies.

Formative Research Findings

A formative assessment (exploratory) was commissioned by Save the Children International in March/April 2015 with pregnant women, mothers of LBW babies, nurse midwives, community and religious leaders, and community members in Thyolo and Machinga to gain insight into their perceptions, knowledge, attitudes, beliefs, practices, and social norms around newborn health, preterm/LBW babies, and KMC. The findings of this research revealed the following.

Misconceptions about preterm delivery

- Having a preterm baby is God's will and there is nothing you can do about it
- Premature delivery is a result of husband or wife's infidelity in marriage,
- It is believed that the first pregnancy is most likely to end in miscarriage or premature birth.
- Preterm delivery is caused by STIs including HIV and other diseases such mwanamphepo or likango.
- Preterm delivery is a result of witchcraft.
- Preterm delivery occurs when a mother continues menstruating throughout the pregnancy.
- It is believed that eating in other people's homes or at a funeral during pregnancy, and a pregnant woman stepping where a dead body is laid at a funeral, result in premature delivery.
- Preterm babies cannot grow and develop into normal persons; development for preterm babies is impaired and most preterm babies are weaklings, become daft or mentally challenged as they grow.
- Premature delivery is an indication that the world is coming to an end.

Barriers to continuous KMC

- Lack of support from husband; in Machinga, polygamy emerged as a key barrier to KMC; it was reported that a majority of men are not be able to support their wives practicing KMC because they have 2 or more wives to take care for.
- Sexual demands from the husband compete with KMC
- Lack of family support
- Women stop doing KMC in order to run businesses and generate income.
- Some mothers run away from the hospital and take the preterm baby to traditional healers for help because they believe that hospitals facilitate new-born death through the use of equipment like oxygen machine kills
- Stigma from neighbours and surrounding community members

Knowledge and understanding of preterm labor and preterm babies was quite high among mothers who had gone through KMC. Participants reported that they didn't know about preterm babies before and it was during this time of delivery they learned about delivering a preterm baby. They recounted experiences of fear and worry upon having a preterm baby. They found KMC very difficult to practice in the beginning, but were motivated to continue practicing in order to save their baby's life. Participants agreed that a KMC peer-mentoring model (partnering mothers practicing KMC with former KMC mothers) would foster the much-needed support and facilitate continuous KMC after discharge.

Fathers of preterm babies reported feeling less of a man as a result of fathering a premature baby. They also felt that KMC was a woman's responsibility.

Nurse midwives indicated that apart from undergraduate training as part of the curriculum, they do not undergo any other training specifically on KMC. Additionally, they are faced with time constraints and inadequate staffing, hence are not able to give comprehensive KMC post-discharge counseling so that clients fully understand the importance of continuing KMC.

Christian religious leaders equated premature birth to a miscarriage; believing that premature birth is a curse because the bible says "among you there shall be no one who will have a miscarriage". According to the religious leaders, premature birth is just like an abortion, and is considered a curse because premature babies die shortly after birth. Muslim religious leaders lamented premature births because in their understanding, if God instituted pregnancies, he meant for the babies to be born after the full term so that they might fulfill God's purpose.

Baseline Findings

A baseline assessment on newborn health, Preterm/low birth weight babies and Kangaroo Mother Care (KMC) was conducted to gather, analyze and document benchmark data for measuring changes in the key social behavior change outcome indicators. Specifically, the assessment sought to collect data on the barriers at community and facility levels that contribute to lack of appropriate care for preterm and low birth weight babies. Below is a summary of findings:

KMC practice at home

Out of total women who (previously) had babies on KMC, mothers continued KMC at home for various duration 28% (16/60) of the total number of mothers interviewed were practicing KMC at home at the date of interviews while 72% (42/60) had discontinued KMC after discharge at the time of data collection. Overall, 69 %(11/16) who had babies LBW on KMC reported practicing KMC every day

KMC practice at home

Overall 93.3% (56/60) of mothers who were discharged from KMC facility returned to the hospital or health facility for follow up care. 3.3% (2/60) of the mothers did not return for follow up and 3.3% (2/60) of KMC mother thought it was not necessary and also that the facility was too far.

Follow up care provided by health worker during follow up visit

Weighing the baby and temperature checks were dominant themes during the follow up visits. Overall 91% (51/56) of babies were weighed during the follow up visit and 71% (40/56) of babies were checked temperature. 29% (16/56) of the mothers were given advice on caring for the baby while 63% (35/56) reported that they were asked about KMC practices at home

Challenges to practice KMC at home

Overall, 83% (50/60) of mothers sited other responsibilities/chores as a major challenge in practicing KMC at home. Other challenges include: caring for other babies 48% (29/60), lack of community support 63% (38/60).

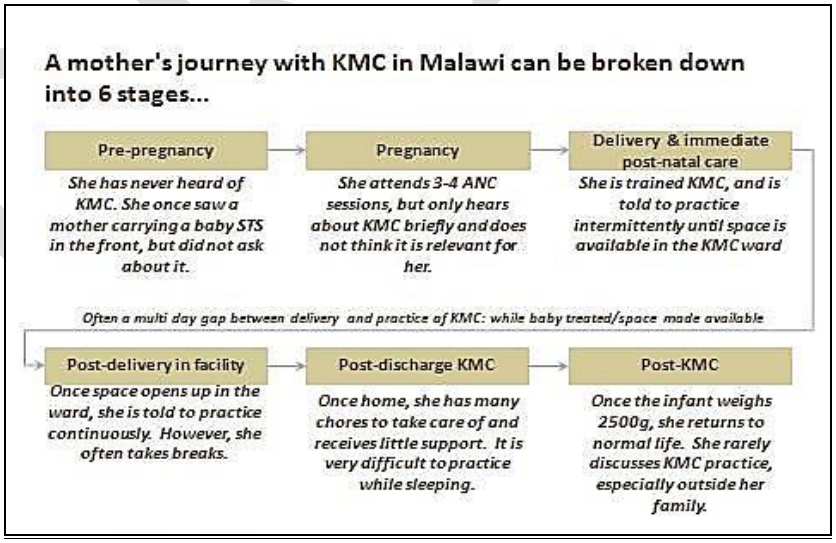
3.1 Current knowledge levels/misperceptions and attitudes

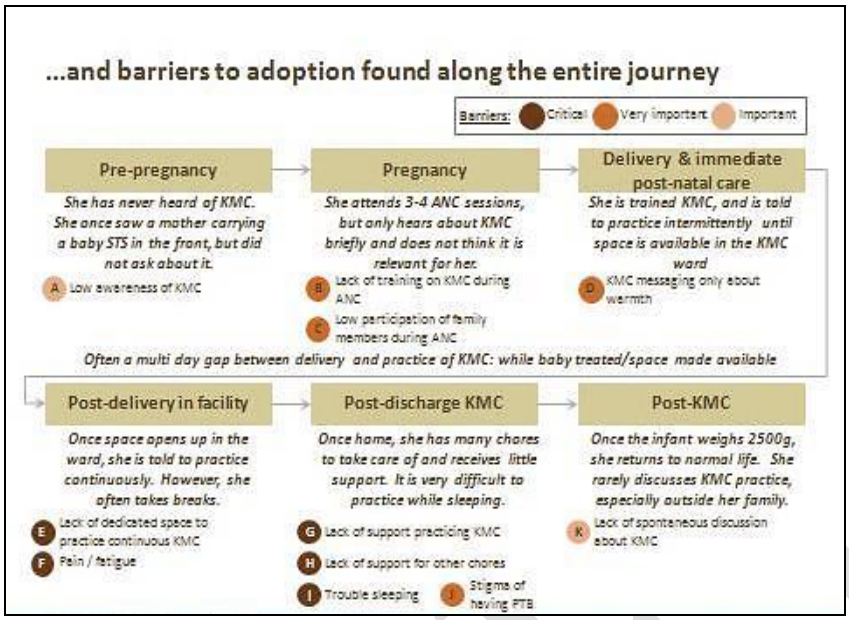
The following knowledge gaps, misperceptions, and attitudes will be probed further in planned exploratory with mothers and providers described in section 7.1 of this document.

- Cultural beliefs around causes of preterm birth/premature babies/new-born death
- Lack of value placed on new-borns especially low birth weight and pre-term
- Lack of self-efficacy in both pregnant woman and health workers
- De-motivated health workers
- KMC not valued by providers as much as more high tech or clinical interventions
- KMC mothers don't recognize warning signs in LBW new-borns

3.2 Current & Competing behaviors/forces

The Boston Consulting Group conducted research with mothers to explore attitudes around KMC, identifying multiple barriers that are listed in the charts below.





In summary, competing forces include:

- Lack of awareness
- Misperceptions (only for warmth)
- Lack of Training (low self-efficacy)
- Pain/fatigue (Exhaustion combining KMC with household chores)
- No dedicated space outside of KMC Unit
- Stigma with pre-term baby
- Limited decision-making power in women
- Tradition & cultural norms (KMC position not socially accepted in public
- Lack of Male/Family Involvement/Support
- Lack confidence to meet babies requirements (for teen mothers)

The following quote from a KMC ward nurse describes lack of male involvement:
"Fathers do not come to the [KMC] ward. Fathers do not get firsthand information from health care professionals, so they do not really understand. Men are afraid to touch babies. Men think that caring is the mothers' job."

3.2 Perceived barriers to the desired behavior

Several barriers are listed above and in the Situation Analysis. In addition, there is a lack of health workers in Malawi and most are over-burdened. This could be de-motivating, leading to poor attitudes towards clients and affecting community member use of available services. In addition, most of the care for mothers and babies in KMC is provided by lower cadre health workers (patient/hospital attendants.)

3.3 Potential benefits for targeted behavior

The following benefits to practicing or promoting KMC will also be probed in an exploratory assessment:

- Saving LBW newborn lives and improving their quality of life
- Earning the respect of peers, family, and community

- Feeling more powerful and in control
- Feeling like part of the effort to decrease maternal and newborn mortality rates in Malawi
- Being thanked by your child as (s)he becomes old enough to appreciate your efforts

3.4 Research gaps

Although quite a bit of secondary research exists on barriers to KMC, there is little research on provider attitudes and practices as they relate to pre-term delivery, low birth weight babies, and KMC. In addition, anectodal evidence pertaining to community values around newborn life and low birth weight babies must also be confirmed. To fill this gap, SNL conducted an exploratory formative assessment among nurse midwives, HSAs and select community members/leaders in the pilot districts. Insights gained have been integrated into this strategy *(refer to section 3.0).*

4.0 Overview of Supply Side

About 80 percent of Malawi's population of over 13 million lives in the rural areas, where only basic health care services are provided, yet the rate of facility births is quite high .The Ministry of Health (Reproductive Health Unit) in partnership with Save the Children, SSDI, ACCESS and UN Agencies of UNICEF, UNFPA and WHO have developed and implemented the Integrated Maternal and Newborn Care Training, whose purpose was to equip facility-based midwives with knowledge, skills and appropriate attitudes in the management of life threatening conditions during pregnancy, delivery and postpartum period. KMC is included in the package.

To train community health workers, the Ministry of Health and partners are implementing Community Based Maternal and Neonatal Health (CBMNH) in which HSAs undergo 10 day CBMNC and 8 day Community Mobilization (CM)training. The aim is to promote community MNH services through CM and to counsel pregnant women. The CBMNH approach emphasizes community mobilization to improve maternal and newborn health. The training equips them with background information on maternal and neonatal health, including KMC, knowledge and skills for communication, counseling and community mobilization.

Other NGOS that have trained HSAs in CBMNH are Maikhanda and Plan Malawi through the Mulanje Program Area. The SHOPS Project has trained Association of Malawi Midwives (AMAMI) personnel as preterm or other critical care supportive supervision trainers.

The Boston Consulting Groups reports that in a survey of 14 healthcare facilities that offered KMC across Malawi in February 2012, only 5 were either 'on the road to institutionalized (KMC) practice' or had evidence of institutionalized practice. Many facilities had poorly trained KMC staff and low provision of information about KMC to mothers during antenatal care / shortly after birth. In only half of the facilities visited, mothers were observed to have 'diligent compliance in doing KMC'. In addition, the process of implementing KMC at Queen Elizabeth Central Hospital in 2003 required many 'compromises' on specific KMC policies and guidelines in order to overcome barriers faced by mothers, and research on early discharge of KMC infants in Malawi identified significant issues with follow-up . Interviews with practitioners have highlighted that Malawi has undertaken quite a lot of training of its practitioners on KMC, and KMC is integrated into the nursing curriculum.

Save the Children International through the SNL project is working to establish KMC sites of Excellence in various district hospitals in in Malawi, including Thyolo and Machinga. The aim is to have well organized KMC services where:

- All LBW/Preterm babies are immediately initiated on KMC after birth unless the baby has a severe complication that requires continuous resuscitation
- All KMC mothers/surrogates are effectively counselled on KMC methodologies
- All KMC mothers are properly coached on how to position their babies on KMC
- All babies are effectively breast feed or cup feed according to their weight and general condition
- All babies are being monitored of vital signs and appropriate action taken
- Criteria for admission; discharge; follow up and discontinuing KMC are properly adhered to by health care providers

SNL is working with the RHD to provide mentorship in Machinga and Thyolo District Hospitals to improve quality of comprehensive new-born care. Specific tasks include visiting the districts to assess the status on neonatal care, identifying any gaps ranging from infrastructure, knowledge and skills gap of health workers, supplies and equipment as well flow of patients, attaching staff to QECH for knowledge and skills acquisition, introducing quality of care audit which includes going through case note by case note for all neonates managed in the nursery for both deaths and those discharged alive, and advocating for expansion of KMC unit in Machinga. SNL has also procured and delivered some critical supplies and equipment to Thyolo and Machinga. Through partnership, Thyolo KMC unit was expanded to a full neonatal ward and fully staffed with funding from MICS project- a Save the Children project also working in Thyolo. SNL is working closely with any partner working in the districts through the district management.

5.0 Objectives

Campaign Goal: The campaign will increase the value of newborn life and community-wide/familial engagement in saving newborn lives, with a focus on low birth weight babies

Communication Objectives

- To increase by 20% knowledge of LBW babies and KMC among pregnant women by July 2016
- To increase by 20% proportion of mothers with low birth weight babies who strongly agree that that KMC is an effective way to save LBW by July 2016
- To increase by 20% the proportion of mothers of LBW babies who report that their community is supportive of KMC by July 2016
- To increase by 50% the number of mothers with LBW who report receiving post-discharge counselling by July 2016
- To increase by 20% the number of mothers of LBW babies who agree that their husband/partner supported me to practice KMC by July 2016
- To increase by 20% the number of pregnant women and mothers who find Medical personnel/health car workers to be a useful source of information for new-born health
- To increase by 20% the number of pregnant women and mothers who find the church to be a useful source of information for new-born health
- Found church to be useful

6.0 Marketing Mix Strategies

We know that information alone does not change behavior. It is therefore useful to think about moving beyond educating to actually *facilitating* a new behavior. Although this intervention will focus primarily on promotion, we can look at newborn health through a marketing lens and the Marketing Mix strategies, also known as the four (4) P's: Product, Price, Place, and Promotion by answering the following questions:

6.1 Product: *How can we make the product, service, or behavior more attractive?*

- Reposition newborns, especially premature babies in the minds of community members and providers
- Position KMC to personalize/humanize it for mothers and fathers and medicalize it for providers
- Consider renaming /repositioning KMC to make it more attractive to fathers and other family members
- Engage the community (community tailors/carpenters)and possibly private sector to design and manufacture new wraps to facilitate continuous KMC and/or a pillow/wedge for making sleeping in KMC position more comfortable; use as income generating opportunity

6.2 *Price: How can we decrease the costs & increase the benefits of the KMC?*

- Consider a voucher scheme. Volunteers identify which women would benefit most from the scheme, then each woman gets a voucher card, entitling them to travel to and from the clinic for follow-up visits or a product that facilitates CKMC.
- Consider rewarding women and their families for continuing KMC at home once they are discharged from the KMC Unit. One incentive might be free wraps branded with the campaign logo and slogan.
- Recognition for HSAs and community volunteers who have provided KMC support after discharge
- Build upon the current Community Score Card Intervention being used in 5 districts by CARE and Plan Malawi.
- Increase the perceived 'value' of newborns and newborn survival

6.3 *Place: How can we increase quality and access to services?*

- Make maternity waiting homes and KMC wards more family friendly with day care for children and places to stay over long periods of time; Utilize waiting homes as a communication channel for KMC promotion
- Improve the interpersonal communication (IPC) skills of providers when promoting KMC to make it more consumer-friendly
- Repackage media materials for use at facilities and in the community and employ providers, HSA's, community volunteers, and Lead Mothers to facilitate discussion
- Conduct KMC Unit open Houses where mothers and families (communities) can see demonstrations
- Provide Mobile KMC support services /Utilize HEU/PSI Mobile video van to promote community-based acceptance of KMC
- Consider piggybacking and expanding upon UNICEF's Baby Friendly Initiative
- Engage KMC veteran mothers as mentors to visit and counsel new KMC mothers

6.4 *Promotion: How can we promote newborn health and popularize KMC?*

The SBCC intervention must communicate on two separate simultaneous levels, through:

- ✓ An umbrella IMAGE component aimed at shifting norms, increasing the value of newborn lives (regardless of size), and mobilizing pregnant women, male partners, family members, and providers and
- ✓ A TACTICAL campaign component that promotes specific behaviors , with a focus on increasing demand for the early initiation of KMC that continues after discharge from the KMC Unit and into the community (CKMC)

Fortunately the SSDI Communication Project has already developed an SBCC campaign with a strikingly similar strategy including an umbrella component (*Life is Precious*.) and a tactical component (*Take care of it.)* The campaign encompasses 6 health areas, including MNH, which we can leverage. We will not create an entirely new stand-alone SBCC strategy, but build upon the investment and success (brand equity) of the SSDI Communication campaign and tap into its implementing partners. The newborn health campaign can be described as a 'product extension' of the 'Life is Precious' brand extending 'Life is precious' to communicate the new take-home message that

Newborn life is precious (no matter how small.) Take care of it.

We may also leverage other stakeholder demand generation efforts and capabilities ; e.g. SHOPS Project newborn health BCC efforts targeting midwife's association, PSI's social marketing and distribution channels, and the UNICEF Baby Friendly Initiative, therefore complementing existing government efforts.

In terms of campaign messengers, according to the SSDI-Communication baseline, health care providers were identified as the main source of health information, followed by community health workers and radio. Men were about 4 times as likely to mention radio as were women. We will also engage religious leaders, both pastors and imams , to promote the value of newborn life, building upon a current SSDI-Communication intervention where pastors are counseling newly married couples. We will also piggyback on an already active community mobilization intervention and create a link between community, media, and facility-based communication.

Communication channels will be community-based, media-based, and facility-based and create 'surround-sound' so that one channel reinforces another. Communities in selected pilot districts will be reached through community mobilization meetings, radio listening groups, and road shows. In addition, they will hear sermons when they go to church or to the mosque. At the same time, they will hear campaign messages on local radio and when they visit the clinic or enter the KMC ward, they will engage in interpersonal communication (IPC) with providers who will provide more detailed information for skill-building. Community health workers will also follow up with mothers who have been discharged from KMC units to support CKMC efforts.

Regarding social media, Information and Communication Technology (ICT) is becoming an important driver of economic growth and behavior change in Malawi. It has been used to enhance smallholder farmer's access to the marketplace and, even more relevant to SNL, Project Concern Worldwide in partnership with Verse SMS/USSD Messaging Service, has

piloted a "Health center by Phone" in order to increase access to services. Chipatala Cha Pa Foni was piloted from 2010-2013 and access to ANC increased by 30%. Concern Worldwide is currently replicating the intervention in Nkhotakota District.

In June 2012, the GSMA mHealth program launched the Pan-African mHealth Initiative (PAMI). PAMI was funded by UK Aid and Norad to support the scale-up of mHealth in nutrition and maternal and child health. PAMI is closely aligned to the UN's Every Woman Every Child Initiative, Scaling Up Nutrition (SUN) and the Global Nutrition for Growth Compact. 44% of the 45 mHealth services in Malawi, which are monitored by the GSMA mHealth Tracker, are focused on maternal and child health, with 16 services featuring demand generation, registration and data surveillance and one health messaging service operated by AirTel. According to the 2014 mhealth Country Feasibility Report , SMS based services can reach up to 400,000 pregnant women and new mothers in Malawi, but have the potential to reach as much as three times if overall access to mobile phones is taken into consideration. Shared phone access which has increased dramatically over the last 5 years, signals a promising trend. It is recommended that partnering in some way on this initiative be pursued.

The timing (roll out) of demand generation will be linked to supply side interventions to ensure that high quality products and patient-friendly services are available upon increased demand. In addition, demand generation will be integrated with an advocacy strategy to ensure that the environment supports healthy decision-making.

See **Creative Briefs** for more details on PROMOTION.

7.0 Plan for Monitoring & Evaluation

Mixed methods will be used to evaluate the intervention. Data on the inputs, process, outputs, outcomes and impact of the intervention will be collected at different points in time. Refer to Table 1 for specific performance indicators, indicator definitions and data collection methods.

Table 1. Performance Monitoring and Evaluation Plan

PEFORMANCE MONITORING AND EVALUATION PLAN							
PERFORMANCE INDICATOR			**DATA ACQUISITION**			**REPORTING**	
Ind. No.	**Performance indicator**	**Indicator Definition and Unit of Measure**	**Data Source**	**Method/Approach of Data Collection**	**Baseline March 2015 & Target July 2016**	**Schedule**	**Responsible Party**
Project Goal: (1) Increased value for newborn at community level. (2). Kangaroo mother care (KMC) for preterm and low bir promoted							
Objective 1: Increased knowledge of pregnant women on KMC and low birth weight babies (LBW)							
1	% of pregnant women who knows/ever heard of KMC.	Total number of pregnant women responded they ever heard of KMC divided by the total number of pregnant women sampled	SBCC Survey (Endline)	Interviews	B= 72 T= 95	By the end of project	SBCC consultant and SNL Meal Staff.

PEFORMANCE MONITORING AND EVALUATION PLAN							
PERFORMANCE INDICATOR			DATA ACQUISITION			REPORTING	
Ind. No.	Performance indicator	Indicator Definition and Unit of Measure	Data Source	Method/Approach of Data Collection	Baseline March 2015 & Target July 2016	Schedule	Responsible Party
2	% of pregnant women who knows/ever heard of LBW.	Total number of pregnant women responded they ever heard of LBW divided by the total number of pregnant women sampled	SBCC Survey (Endline)	Interviews	B= 91 T= 100	By the end of project	SBCC consultant and SNL Meal Staff.
3	% of pregnant women who knows that anyone can give a (preterm) baby	Total number of pregnant women responded they know that anyone can give a LBW divided by the total number of pregnant women sampled	SBCC Survey (Endline)	Interviews	B= 98 T= 100	By the end of project	SBCC consultant and SNL Meal Staff.
4	% of pregnant women who knows the benefit of KMC by type of benefit	Total number of pregnant women responded reported knowing the benefit of KMC divided by the total number of pregnant women sampled	SBCC Survey (Endline)	Interviews	Thermo protection (B=84, T=95)	By the end of project	SBCC consultant and SNL Meal Staff.
					Nutrition (B=7, T=60)	By the end of project	SBCC consultant and SNL Meal Staff.
					Brain maturation (B=5, T=60)	By the end of project	SBCC consultant and SNL Meal Staff.
					Minimizes Infection (B=5, T=60)	By the end of project	SBCC consultant and SNL Meal Staff.
1.1.1.1.1.1	**Objective 2: To increase by 20% the proportion of mothers who strongly agree that that KMC is an effective wa**						
5	% of mothers with a LBW baby who strongly agree that KMC is an effective way to save LBW	Total number of mothers with a LBW baby who strongly agree that KMC is an effective way to save LBW divided by the total number of mothers with a LBW baby	SBCC Survey (Endline)	Interviews	B= 22 T= 44	By the end of project	SBCC consultant and SNL Meal Staff.

PEFORMANCE MONITORING AND EVALUATION PLAN							
PERFORMANCE INDICATOR			DATA ACQUISITION			REPORTING	
Ind. No.	**Performance indicator**	**Indicator Definition and Unit of Measure**	**Data Source**	**Method/Approach of Data Collection**	**Baseline March 2015 & Target July 2016**	**Schedule**	**Responsible Party**
1.1.1.1.1.2	**Objective 3: To increase by 20% the proportion of mothers with LBW who reported that their community is sup**						
6	% of mothers with a LBW baby who reported that their community is supportive of KMC	Total number of mothers with a LBW baby who reported that their community is supportive of KMC divided by the total number of mothers with a LBW baby	SBCC Survey (Endline)	Interviews	B= 64 T= 84	By the end of project	SBCC consultant and SNL Meal Staff.
1.1.1.1.1.3	**Objective 4: To increase by 50% the proportion of mothers with LBW who reported to receive post discharge c** ***will also be captured in the qualitative aspect covering details of counseling)****						
7	% of mothers with a LBW baby who reported to receive post discharge counselling on KMC during the follow up visit	Total number of mothers with a LBW baby who reported to receive post discharge counselling on KMC during the follow up visit divided by the total number of mothers with a LBW baby	SBCC Survey (Endline)	Interviews	B= 28 T= 78	By the end of project	SBCC consultant and SNL Meal Staff.
1.1.1.1.1.4	**Objective 5: To increase by 20% the proportion of mothers with LBW who agree that their husband/partner sup KMC**						
8	% of mothers with a LBW baby who reported that their husband supported them to practice KMC	Total number of mothers with a LBW baby who reported that their husband supported them to practice KMC divided by the total number of mothers with a LBW baby	SBCC Survey (Endline)	Interviews	B= 52 T= 72	By the end of project	SBCC consultant and SNL Meal Staff.
1.1.1.1.1.5	**Objective 6: To increase by 20% the proportion of mothers with LBW who reported that church is source of use**						
9	% of mothers with a LBW baby who reported that church is source of useful information on KMC	Total number of mothers with a LBW baby who reported that church is source of useful information on KMC divided by the total number of mothers with a LBW baby	SBCC Survey (Endline)	Interviews	B= 36 T= 56	By the end of project	SBCC consultant and SNL Meal Staff.

PEFORMANCE MONITORING AND EVALUATION PLAN							
PERFORMANCE INDICATOR			DATA ACQUISITION			REPORTING	
Ind. No.	Performance indicator	Indicator Definition and Unit of Measure	Data Source	Method/Approach of Data Collection	Baseline March 2015 & Target July 2016	Schedule	Responsible Party
1.1.1.1.1.6	**Objective 7: To increase by 20% the proportion of mothers with LBW who reported that facility providers is ve information on KMC**						
10	% of mothers with a LBW baby who reported that facility providers is useful source of information on KMC	Total number of mothers with a LBW baby who reported that facility providers is useful source of information on KMC divided by the total number of mothers with a LBW baby	SBCC Survey (Endline)	Interviews	B= 55 T= 75	By the end of project	SBCC consultant and SNL Meal Staff.

7.1 Baseline Formative Assessment

A mixed methods formative assessment was conducted before implementation of the SBCC intervention. The purpose of this formative assessment was twofold; to inform content and implementation of the SBCC intervention, and to serve as a baseline for assessing progress and outcome of the intervention. Baseline information on knowledge, practices, beliefs, norms, attitudes on pre-term birth (PTB), low birth weight (LBW) babies, and KMC was collected qualitatively from health care workers (nurse midwives), young married pregnant women, women and men who have already experienced a preterm delivery and have gone through KMC, and community and religious leaders.

7.2 Process Measures

Data will be collected to assess the quality of activities and to ensure that the targets are being reached. Monitoring forms will be used to collect data for monitoring all community based activities including community discussions, road show events etc., and mass media will be monitored accordingly. Data collected will include number of activities done or materials produced, distribution of materials,

7.3 Output Measures

Data will be recorded for all activities (number of community discussions, road show events, airing and facility/community use of radio jingles, radio spots and digital stories) using participant feedback /monitoring form, post discussion questionnaires and observation. Data will be collected on participation during activities, actions taken after community discussions, number of campaign messengers trained etc.

7.4 Outcome (End-line) Evaluation

A mixed methods end-line evaluation will be conducted at the end of the SBCC newborn health intervention to determine the outcomes of the intervention (whether the intervention

has achieved its goal). The evaluation will aim to solicit feedback from the primary and secondary target audiences regarding how they have received and perceived communication materials and interventions, and assess the self-reported impact of the intervention on the target audience. The evaluation will involve conducting focus group discussions (FGDs) with pregnant women, women who have given birth to LBW babies, their spouses and families, as well as health care workers, religious leaders and other campaign messengers who will be trained in IPC. Quantitative data will be collected through a survey, and qualitative data will be collected through focus group discussions, individual in-depth interviews, and case studies. The outcome measures for all the target audiences will include knowledge, beliefs, self-efficacy and around newborns, preterm babies and KMC.

7.5 Impact Evaluation

A KMC special study (quantitative) will be conducted to assess the impact of the intervention; i.e. whether the intervention has increased the value of newborn lives and increased demand for quality KMC.

8.0 Work/Activity Plan & Timeline

ACTIVITY (TO TAKE PLACE IN THYOLO & MACHINGA)	**MATERIALS (ON CD/USB & HARD COPY)**	**RESPONSIBLE PARTY**	**DISSEMINATION DATE** (2015-2016)
MESSENGER TRAINING WORKSHOP (PASTORS, IMAMS, PROVIDERS, VETERAN KMC MOTHERS, COMMUNITY LEADERS)	MESSENGER TOOLKIT (CAMPAIGNMATERIALS, FACILITATOR'S GUIDE, SIGNAGE, SCRIPTS, ETC.)	SNL-MONICA/LYNDA	MID OCTOBEREARLY SEPTEMBER
CAMPAIGN LAUNCH (WITH SPOKESPEOPLE/CHAMPIONS)	CAMPAIGN BANNER, JINGLE, DIGITAL STORIES, PRESS RELEASE	SNL-MEDIA TEAM/MONICA	MID-LATE SEPTEMBER END OCTOBER
PROCESS EVALUATION	QUESTIONNAIRE	TBD	ON-GOING
AIR RADIO SPOTS LOCAL RADIO	RADIO SPOTS (x2), JINGLE	TBD	SEPTEMBER END OCT. 2015-JULY AUGUST 2016
AIR DIGITAL STORIES (AS PART OF CURRENT CNN RADIO SERIES)	DIGITAL (KMC SUCCESS) STORIES	TBD	SEPT NOV. 2015-AUGUSTJULY 2016
FACILITY-BASED DISCUSSIONS	RECYCLED RADIO DRAMA, DIGITAL STORIES, (FLIP CHART) & FACILITATOR'S GUIDE	ANNA-MONICA	SEPT END OCT. 2015-JULY AUGUST 2016
COMMUNITY-BASED DISCUSSIONS	MESSENGER TOOLKIT MATERIALS	MONICA/LYNDA	SEPT END OCT.2015-JULY AUGUST 2016
ROAD SHOW EVENTS (1-2)	CAMPAIGN BANNER	SSDI-SNL MONICA	MARCH-APRILJAN-FEB 2016
SMS MESSAGES FROM	SAMPLE MESSAGES	TBD	AS NEEDED

PROVIDERS TO PATIENTS			
SUMMATIVE EVALUATION		SNL-JAMES	MAYJUNE--JULY AUGUST 2016