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निजी सचिवालय
रामशाहपथ, काठमाण्डौ ।
मन्त्रालय फोन नं: ९७७-१-४२६२५४३
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FEW WORDS

Nepal, through the progressive implementation of the health initiatives in the past two decades, has made great achievements to improve maternal, neonatal and child survival. Although the situation has improved, every year 281 maternal deaths per 100,000 live births is still estimated, 6 out of 100 children are likely to die before their fifth birthday, and 5 of 100 babies die before their first birthday. Maternal, newborn and child is a high priority, given the high maternal, newborn and child morbidity and mortality rates in Nepal. It is one of the major concerns addressed by various global and national commitments, as reflected in the targets of the Millennium Development Goals, The Essential Health Care Services, and Nepal Health Sector Program-II among others.

Maternal and newborn deaths are caused by factors attributable to pregnancy, childbirth and poor quality of health services. Child health depends heavily on availability of and access to immunizations, quality management of childhood illnesses and proper nutrition. Access to these services is impacted by social factors of gender, caste/ethnicity, regional identity, and income. To address the low health status and disparities in maternal, neonatal and child health across the country and to improve access to quality health services for the mother, newborn and child requires evidence-based and goal-oriented health and social policies and interventions. Under this background, National Communication Strategy for Maternal, Newborn and Child Health 2012-2016 has been developed to accelerate the reduction of maternal, newborn and child deaths.

This strategy document spells out various approaches to guide all stakeholders for maternal, newborn and child health, including the government, non-governmental organizations, development partners, civil society organizations, private health sector, and communities, in working together towards attainment of the Millennium Development Goals as well as other national commitments and targets related to maternal, newborn and child health. The Government highly values your partnership in working towards realization of the objectives of the National Communication Strategy for Maternal, Newborn and Child Health to improve maternal, newborn and child health. Together, we can improve health of Nepalese mothers, babies and children, and build a stronger and more prosperous nation.

I would like to acknowledge to generous technical and financial contributions from organizations and individuals who were instrumental in the development of this strategy document. I would also take this opportunity to recognize the dedicated service and hard work of all health personnel at all levels of service delivery, who are on the front-line of national efforts to ensure improved maternal, neonatal and child health.

February 2012


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Rajendra Mahato
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The health sector is significant to social and economic development with enough facts linking to quality of health care as there is a popular saying; 'Health is Wealth'. In this process, Nepal has made considerable achievements in improving maternal, newborn and child health over the past few years. Maternal mortality has declined by half in between 1996 to 2006 to a ratio of 281 per 100,000. Deaths of children below five years of age have decreased by 48 percent in the past 15 years. Deaths of infants have declined by 41 percent. However, the achievements are still not satisfactory. There are many disparities between different social groups. The situation is not acceptable, especially as most of the mothers, newborns and children are dying due to preventable causes. The level of mortality is worsened particularly by poverty, inadequate maternal education, poor nutrition practices, lack of safe water, sanitation and high fertility, and inadequate birth spacing.

Reducing mortality in newborns, children under 5 years of age and improving maternal health is part of Nepal's commitment to the Millennium Development Declaration as well as towards attainment of national MNCH intervention related commitments and targets. Reducing health inequalities is also a commitment of the Interim Constitution of Nepal, GoN. MoHP has also identified addressing gender based discrimination and violence against women as key priorities. In response to this challenge, the National Communication Strategy for Maternal, Neonatal and Child Health will upgrade national efforts towards MNCH issues. The strategy is expected to guide Nepal health sector program II, and a platform for achieving the MDGs. This strategy is being articulated as an important guide to address maternal, neonatal and child health issues and serve as the basis for program implementation by all stakeholders - government, development partners, civil society, private sector, communities, etc. I hope that this strategy will pave the way for improved maternal, newborn and child health. No mother, newborn or child should die from avoidable causes just because the information on these services or preventive health behaviour was not accessible to them.

The Ministry of Health and Population is working to improve maternal, newborn and child health of Nepal in an equitable and sustainable manner through the provision of quality health services and healthy life styles. It is the expectation of the Ministry of Health and Population that all stakeholders will make optimal use of this strategic framework to support the implementation of maternal, newborn and child health interventions. We are committed to preventing all avoidable deaths of our mothers, babies and under 5 children. I would take this opportunity to request all our partners to support this strategy and align their resources and programs to ensure its harmonized implementation.

In this endeavor, I request all stakeholders to use this strategy to adequately address the gaps and program interventions towards the delivery of quality, efficient and sustainable health care for all mothers, newborns and children. I am confident that our joint efforts will help in achieving the maximum health benefits for all mothers, newborns and children of Nepal.

I would like to congratulate the National Health Education, Information and Communication Centre (NHEICC) for leading the development of this strategy and other stakeholders for enriching this document with their valuable expert input. Thanks for your untiring efforts to improve the lives of Nepal's women and children.

February 2012

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Dr. Praveen Mishra
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PREFACE

Nepal has achieved significant reductions in infant, child and maternal mortality in the past two decades through the implementation of several health initiatives. However, the situation still remains where 6 out of 100 children die before their fifth birthday, 5 out of 100 babies die in the first month of life and 281 mothers per 100,000 live births die. This is unacceptable in the 21st century. Existing harmful cultural health practices, gender discrimination and social exclusion, low status of women, early marriage and child birth, frequent pregnancies, nutritional deficiencies and other undesired behaviours must be addressed.

At the United Nations Millennium Summit in 2000, Nepal made its commitment to achieving the Millennium Development Goals, which include reducing mortality in infants and under five children and improve maternal health by two-thirds the year 2015. Nepal is on track to achieve MDGs related to women and children. However, efforts must be sustained to achieve them.

In response to this challenge, there is a need to deal with the health barriers faced by women of all social groups of Nepal and their babies before and during pregnancy, during delivery and in the following weeks and months. This National Communication Strategy for Maternal, Neonatal and Child Health will help guide Ministry of Health and Population and other concerned stakeholders to jointly plan and implement maternal, neonatal and child health communication programs for coordinated strategic action.

In line with the Second Long Term Health Plan, Nepal Health Sector Programme-II and Gender Equality and Social Inclusion Strategy in Health (2010, MoHP) this strategy document will be instrumental in scaling up the maternal, neonatal and child survival interventions through the active participation of the community, the relevant sectors, local and international partners and other stakeholders.

I appreciate National Health Education, Information and Communication Centre for their effort and leadership to bring this strategy in this stage. Similarly, I appreciate all those who were involved and contributed to the formulation of this important strategy to ensure the survival and well-being of mothers and their children. I would like to urge all concerned line ministries, NGOs, INGOs, external development partners, private sectors and other related stakeholders to follow this strategy while implementing health communication activities.

February 2012

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Dr. Yashobardhan Pradhan
Director General
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ACKNOWLEDGEMENT

The National Communication Strategy for Maternal, Neonatal and Child Health is the outcome of a participatory and consultative process involving stakeholders and partners working in the area of maternal, neonatal and child health led by Government of Nepal, Ministry of Health and Population, National Health Education, Information and Communication Centre (NHEICC). It comprises major components of health such as maternal and newborn health, the community based integrated management of childhood illnesses (CB-IMCI), expanded programme on immunization (EPI) and nutrition.

This strategy document will guide implementation of all maternal, newborn and child health IEC/BCC interventions in Nepal and support in achieving the Nepal Health Sector Programme-II vision and objectives and the health targets of Millennium Development Goals.

I would like to express my sincere gratitude to Dr. Praveen Mishra, Secretary of Ministry of Health and Population for his encouragement and direction to develop this strategy. I am, also, grateful to Dr. Sudha Sharma, former secretary of Ministry of Health and Population for her encouragement to develop this strategy.

I would like to express my sincere gratitude to Dr. Yashobardhan Pradhan, Director General of Health Services, DoHS for his leadership guidance and valuable support to develop this strategy.

NHEICC wishes to acknowledge national and international development partners, donors, stakeholders and different government and non-government organizations who actively participated in the strategy development process for their generous efforts, support, contributions and commitment. This document would not have been possible without the enthusiastic participation and contribution from director, section chief and other officers of FHD and CHD including all the partners of NHEICC particularly WHO, UNICEF, UNFPA, Save the Children, HSSP/GIZ, NHSSP/DFID, NFHP/USAID.

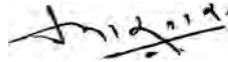
The experts from ministry of health and population, different divisions, centers and technical fields have kindly provided their inputs to make this document as comprehensive as possible. NHEICC greatly appreciate to the program managers, section chiefs and senior officers of Safe Motherhood and Newborn health, Nutrition, EPI and CB-IMCI programs for their untiring support and contribution during the strategy development process.

I very much appreciate the hardworking team of Safe Motherhood, Newborn and Child Health Communication Technical Committee to facilitate the work for reviewing the existing program communication activities relating to safe motherhood, newborn health and child health and for providing inputs to this strategy.

I would like to thank Dr. Madhu Devkota for facilitating the strategy development process and drafting the strategy. Similarly, special thanks goes to Dr. Yogendra Bhakta Pradhanang for his contribution in refining the strategy. The technical and financial support from the Save the Children, WHO and UNICEF is highly appreciated. Finally, a vote of thanks is extended to Ms. Caroline Jacoby and her colleagues of JHU/CCP for the final editing of this strategy.

Also, I thank the senior officials of NHEICC for their dedicated support, solidarity and teamwork in developing this strategy. I believe that all stakeholders will take this strategy as guiding document for health communication program planning and implementation. I look forward to our continued productive collaboration in the future.

February 2012



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Badri Bahadur Khadka
Director

National Health Education, Information and Communication Centre

LIST OF ACRONYMS

AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASRH	Adolescent Sexual Reproductive Health
BCC	Behaviour Change Communication
CB -IMCI	Community-based Integrated Management of Childhood Illness
CB- NCP	Community-based Newborn Care Programme
CDD	Control of Diarrheal Diseases
CHD	Child Health Division
CMAM	Community Management of Acute Malnutrition
DHO	District Health Officer
DPHO	District Public Health Officer
DDC	District Development Committee
EDP	External Development Partner
EPI	Expanded Programme on Immunization
EHCS	Essential Health Care Service
ECD	Early Childhood Development
EBF	Exclusive Breast Feeding
FCHV	Female Community Health Volunteer
GM	Growth Monitoring
GESI	Gender Equality and Social Inclusion
HA	Health Assistant
HCP	Health Care Provider
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HW	Health Worker
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorder
IEC	Information, Education and Communication
INGO	International Non-governmental Organization
IPC	Inter-Personal Communication
IYCF	Infant, Young Children Feeding
LBW	Low Birth Weight

MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MCHW	Maternal & Child Health Worker
MIL	Mother-in-Law
MMM	Maternal Mortality and Morbidity study
MNCH	Maternal Newborn Child Health
MNC	Maternal Newborn Care
MNP	Micro-nutrient Powder
MOHP	Ministry of Health and Population
NAGA	Nepal Nutritional Assessment and Gap Analysis
NDHS	National Demographic Health Survey
NFE	Non-formal Education
NGO	Non-Governmental Organization
NHEICC	National Health Education, Information and Communication Centre
NID	National Immunization Day
NIP	National Immunization Programme
NMR	Neonatal Mortality Rate
ORS	Oral Rehydration Solution
PEM	Protein Energy Malnutrition
PENP	Protein Energy Nutrition Promotion
PHCC	Primary Health Care Center
PMTCT	Prevention of Mother to Child Transmission of HIV
RHD	Regional Health Directorate
SBA	Skilled Birth Attendant
SLTHP	Second long Term Health Plan
SMS	Short Message Services
SSMP	Support to Safe Motherhood Programme
STI	Sexually Transmitted Infection
TT	Tetanus Toxide
VAD	Vitamin A deficiency
VHW	Village Health Worker
VDC	Village Development Committee

EXECUTIVE SUMMARY

Nepal has made remarkable progress in improving health and nutritional status of children. These achievements can be attributed to effective health service delivery, health campaigns and behaviour change communication efforts lead by government of Nepal. As a result Nepal is on track to meet MDG 4 and 5. However, inequalities in access to health care services persist that leads to poor maternal health significantly contributing to the risk of death in newborns and children below five years of age. The National Health Policy of 1991, the Second Long Term Health Plan (SLTHP 1997-2017) and the new Nepal Health Sector Programme-II (2010-2015) aims to improve the health and nutritional status of the Nepali population, especially the poor and excluded groups, with a strong focus on mainstreaming efforts to combat gender discrimination and social exclusion. Considering the situation, the strong need for evidence based; locally appropriate; socially inclusive and updated national communication strategy on the priority elements of EHCS particularly on MNCH was felt.

In this regard, NHEICC initiated the development of comprehensive Maternal, Newborn, Child Health (focusing Expanded Programme on Immunization and Integrated Management of Childhood Illness and Nutrition) national communication strategy through series of workshops, working group meetings, desk review, situation analysis involving stakeholders and experts. This comprehensive communication strategy document intends to provide a blueprint for focussed behaviour change communication (BCC) interventions to improve the health and nutritional status of women and children in Nepal. This communication strategy document is evidence based and uses theory of communication for social change and "Nepal Pathways to maternal, newborn and child health" model as its conceptual foundation. Also, it is one of the first communication strategy document that clearly spell out priority behaviours across the spectrum of life cycle approach. Extensive evidence based behavioural barriers analysis for all maternal and child health program were undertaken. Based on this analysis, behavioural log frames were prepared from conception to the critical first five years life of a child.

The goal of the MNCH communication strategy is to contribute to increasing access to and utilization of improved maternal, newborn and child health information and quality services. The main strategic objectives of the national communication strategy for MNCH are to:

- ▶ Promote and improve knowledge, high self-efficacy, supportive norms for maternal, newborn, child health, nutrition related behaviours in all social groups.
- ▶ Enhance demand for and access to maternal and child health and nutrition services among all caste, ethnic groups, disadvantaged and hard to reach population.

- ▶ Strengthen mobilization of national and community resources to support pregnancy, child birth, postnatal and neonatal care, nutrition of infant, adolescents and pregnant mothers, management and treatment of childhood illness and immunization.

Individual and community requires communication interventions at three levels to generate political and social commitment, change social norms and values and strengthen knowledge, attitudes and practices. So, audiences have been identified for communicating messages in line with 3 mutually reinforcing strategic communication approaches such as advocacy, social mobilization and behaviour change communication. The audiences and their relationship between strategic communication approaches have been described in order to reach wider spectrum of audiences. Pregnant women and mothers of all social groups are primary audiences of MNCH communication strategy.

The existing and expected behaviours of target audiences are described in the strategy to develop messages for communication based on the major issues in MNCH. Though, Nepal has made remarkable strides in maternal and child health outcomes, the mortality rate among pregnant women and children aged less than one year has decreased substantially over the last two decades. Infant mortality is still 48 per 1,000 live birth, among this neonatal mortality contributes the higher proportion. Moreover, progress is uneven across spatial and socio-economic lines. The data suggest that majority of under-five deaths (54%) occur in the first month of their lives, more specifically within 24 hours of birth.

The maternal mortality rate for 2009 was estimated to be 280 per 100,000 live births, among the highest in Asia. Most maternal and newborn deaths are a direct consequence of limited knowledge about pregnancy and child birth and under-utilization of appropriate health systems and low quality of care, especially in rural areas. About 82 per cent of all births take place at home without presence of skilled birth assistance.

General malnutrition is a persisting problem in Nepal with almost 50 per cent of Nepal's children still suffering from chronic malnutrition -49% of children under five years are stunted, and 39% are underweight (NDHS 2006). Rural children fare significantly worse than their urban counterparts (51% vs. 36% stunting, 41% vs. 23% under-weight). The consequences of stunting are profound, life-long and irreversible. Children of illiterate mothers and from households in the lowest health quintile suffer the most from malnutrition. Malnutrition is a serious obstacle to survival, growth and development of children. Poor quality of complementary foods – inadequate levels of essential vitamins and minerals – is a major problem for Nepali children since traditional complementary foods are largely starch-based. Poor hygiene and sanitation situation and health seeking behaviour and limited knowledge among

the parents and care takers has been key determinants in poor health outcome of women and children in Nepal.

Limited knowledge of pregnancy and newborn care, available health services and various social and traditional practices in Nepal are increasing the risks for mother and newborn. Promotion of institutional delivery, caring of pregnant women and newborn will be vital to improve maternal and newborn health outcomes. Priority trigger behaviours across all family and child health programs have been selected based on evidence of association of the behaviours to prevent outcomes such as maternal, neonatal and child mortality, anaemia, malnutrition etc. and potential for change through various communication approaches.

The major technical content headings are identified in the national communication strategy to develop detail technical content and messages for communication to the target audiences. Content headings and statements are identified based on the issues and desired behaviour change to the target audiences. Technical contents have been identified and described in 4 headings as ANC, delivery, post natal care and safe abortion in SMNH, 7 headings as hygiene and sanitation, diarrhoea, ARI, Pneumonia, malaria, measles and new born care in IMCI, 3 headings as routine immunization, supplementary immunization and AFP in EPI and 2 headings as hygiene and sanitation and age-wise technical content focused on newborn, children, adolescent and women in nutrition.

The communication strategies for interventions on SMNH, IMCI, EPI and nutrition are focused on three mutually supporting communication approaches namely advocacy communication, social mobilization communication and behavioural change communication.

Communication interventions and activities for MNCH communication strategy document seeks to address the gaps in behaviourally focussed, socio-culturally driven community led communication approaches. It focuses an excessively on electronic mass media, which is reinforced by interpersonal, community and group media. The strategy shifts the emphasis on BCC programs from awareness to action. The strategy aims at convergence of behavioural focus, associated persuasive inputs and synchronization of resources. An integrated five-year strategy at the interpersonal, community and mass media levels of communication is being proposed to adopt healthy behaviours.

MNCH communication strategy centres on using interpersonal communication and community level BCC activities supported by mass media and community mobilization interventions. The strategy aims to build on vast community based resources available in Nepal and to build the capacity of Female Community Health Volunteers to be act as effective change agents. Mobilization of mother groups, child clubs and other existing community groups has been proposed for adopting healthy behaviours related to pregnancy and child health.

The strategy recognizes that the role of mass media needs to be redefined given the limited reach of mass media channels in the rural and high mountainous districts on the one hand and the increasing emergence of alternate media such as mobile phones and social networks on the other. Approaches to extend the reach of the traditional mass media channels and tapping the numerous local FM stations operational at the community levels. Innovative use of “social networking sites”, portable DVD players, SMS campaigns etc. is suggested to extend the reach of electronic mass media channels.

The strategy proposes interventions at the national, facility, community and household levels. The effective implementation of the communication strategy is dependent on partnerships, coordination and collaboration with development partners, NGOs and CBOs. The BCC innovations proposed in the strategy document include an IPC tool for home visits by FCHVs, the use of cell phones and SMS for increasing male and young people involvement.

Capacity building efforts should include an orientation for all health care workers on the “Basics of BCC. Detailed plan for capacity building for effective BCC planning, implementation, supervision and monitoring is required to be worked out for the future. District and community level BCC resource centre need to be established. The innovative BCC interventions outlined in the strategy document need to be pilot tested and impact assessed before up scaling.

Monitoring and evaluation of the communication strategies and activities will be done through NHEICC along with the relevant division and stakeholders following indicators identified in the strategy from the national level to community level. Major behavioural indicators such as knowledge, attitude and desired practices for SMNH, IMCI, EPI and nutrition are listed in the strategy. Necessary information will be solicited from regular HMIS data and periodic survey data. The strategy document also defines the BCC input, output and outcome indicators in the section on monitoring and evaluation. Evaluation studies to scientifically assess the impact of BCC have also been proposed.

A detailed set of recommendations for operationalizing the strategy are provided in the document as implementation and management structure. Coordination mechanism among partners is ensured by forming coordination and technical committees. The existing health system network of NHEICC, FHD, CHD, regional health directorate, district health/public health offices, PHCs, HPs and SHPs from central to the community including FCHVs will be utilized to implement communication strategies. A detailed implementation plan for the different components of the strategies will be developed after strategy endorsement, in which specific strategies, objectives, audiences, messages, channel, timeline, responsibilities, resources, outputs and means of verifications are outlined.

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1.1. BACKGROUND

Nepal has taken initiatives that have achieved significant reductions in infant, child and maternal mortality, while improving equity of access to health services.

Maternal mortality has declined by half between 1996 and 2006 to a Maternal Mortality Ratio (MMR) of 281 in 2006, a 26% drop per annum (NDHS 2006, Suvedi et al 2009) Even so, to reach Nepal's MDG 5 target of 134 by 2015, the MMR must continue to decline at least 13% per year.

Mortality of children below five years of age has decreased significantly from 118 per thousand in 1996 to 54 per thousand in 2011. In the same period, infant mortality has also declined from 79 to 46 per thousand live births. Reaching the MDG 4 target of 15 per 1000 live births from 33 per 1000 live births reported in 2002 (NDHS 2002) is considered likely with continued effort.

Nepal remains one of the most malnourished countries in the world, with 41% of under five year olds stunted, indicating early chronic malnutrition. Malnutrition reduces a child's survival chances, causes permanent impairment of physical and cognitive development, and perpetuates poverty by reducing achievement in school and future earnings.

Disaggregated data on these indicators reveals that gender, caste/ethnicity, income and location based disparities exist. Nutritional status is significantly lower for the poor than the rich and for rural populations; maternal under nutrition is also higher in the lower wealth quintiles compared to the highest. Child stunting is the highest in the Terai at almost 40 percent¹.

There is clearly a need for a multi-pronged approach that tackles problems associated with childhood malnourishment in Nepal. Such an approach would seek action on the part of:

¹Review of Nepal Experience and Global Evidence for Essential Nutrition Interventions to Support Planning for Scaling-up Nutrition Interventions in the Nepal Health Sector Programme (NHSP-2)

- ▶ Government and non-government agencies to formulate and implement effective policies that alleviate poverty and provide access to nutrition and health care services, and address different kinds of discrimination based on gender, caste/ethnicity, regional identity and geographical location
- ▶ National, district, and local organizations to advocate on behalf of families and communities,
- ▶ Healthcare sector members to provide optimal services and care, and
- ▶ Families, of different social groups to become knowledgeable and able to enact behaviours on behalf of their children.

Building on the National Health Policy of 1991, the Second Long Term Health Plan (SLTHP 1997-2017), and Nepal Health Sector Programme 2004-2009 (NHSP-IP I), the new Nepal Health Sector Programme-II (2010-2015) aims to improve the health and nutritional status of the Nepali population, especially the poor and excluded groups, with a strong focus on mainstreaming efforts to combat gender discrimination and social exclusion.

Under the NHSP- II, the scope of health communication efforts aims to:

- ▶ Raise awareness and knowledge about factors that affect mother and children's health and well-being
- ▶ Increase community participation
- ▶ Improve gender sensitivity and reduce social exclusion
- ▶ Help communities of different social groups and families identify health problems and solutions
- ▶ Increase the utilisation of available health services, and
- ▶ Advocate for improved access to quality health services.

The National Health Education Information and Communication Centre (NHEICC) was established in 1993 with the goal of contributing towards the attainment of the highest level of health of the people by giving high priority to information, education and communication. This centre is responsible for developing, producing, and disseminating messages to promote and support all health-related programmes and services in an integrated manner. Health education, information and communication programmes are implemented throughout the country in 75 District Health/Public Health Offices by using various media according to the needs and opportunities in the district and community.

A sound communication strategy is critical for enhancing the effectiveness of public health programmes in order to meet the Nepal Health Sector Programme-II (2010-2015) goals and objectives.

NHEICC has led coordination of communication activities through development of national communication strategies in the past. These include the Safe Motherhood Information, Education and Communication Strategy (SMIEC) and the National Family Planning/Maternal and Child Health (FP/MCH) Strategy. The current strategy seeks to provide an integrated, gender and inclusion sensitive framework for maternal, newborn, child health and nutrition strategies. At the time of this writing, the National Family Planning Communication Strategy and the National Adolescent Sexual and Reproductive Health Strategy 2012-2016 are being developed separately.

I.2 RATIONALE FOR COMMUNICATION STRATEGY AND STRUCTURE

The rationale for a new strategy is:

- ▶ To support NHSP II's vision, objectives and the results framework and contribute towards achieving the health-related MDGs
- ▶ To scale up successful interventions and plan on the basis of lessons learned
- ▶ To update SMIEC and FP/MCH strategies and develop Nepal's first national communication strategies for Maternal and Child Health such as SM, Newborn, EPI, IMCI and Nutrition in an integrated fashion
- ▶ To address the continuing low health status and disparities on MNCH across different regions, communities, groups, and gender
- ▶ To garner ownership of the MNCH programmes by all stakeholders from the central government to local communities in recognition of decentralization and the important role of households and communities in improving MNCH
- ▶ To facilitate resource generation and resource allocation for communication activities in the respective programmes.

This strategy is organized via government programme so that each programme can see how their section fits into the overall communication strategy, but easily find the objectives, audience, content and indicators for their individual programme sections.

I.3 STRATEGY DEVELOPMENT PROCESS

NHEICC initiated the process for this communication strategy to address safe motherhood and newborn health, the community based integrated management

of childhood illnesses/newborn care program (CB-IMCI/NCP), expanded programme for immunisation (EPI) and nutrition.

First, a desk review and situation analysis were prepared. Based on findings, a SMNCH Communication Technical Committee developed an integrated Communication Strategy draft.

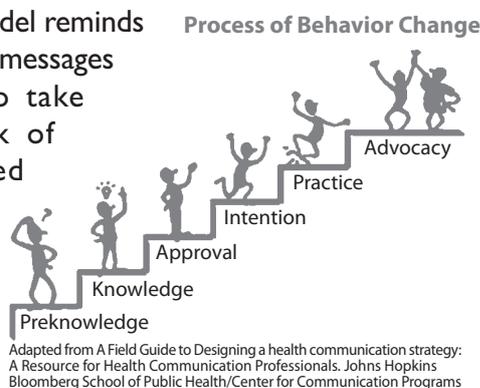
Workshops were organised to work on the different components of communication strategy where stakeholders and programme managers reviewed and provided input. Communication and program experts reviewed the final strategy.

2.1. FRAMEWORK FOR COMMUNICATION STRATEGY

Communication is an integral component to support services by getting the MNCH messages and information out to the target audiences in a way they can understand and act on. Communication programmes help audience members overcome specific barriers so they can practice the new healthy behaviours. The following Steps to Behaviour Change and Pathways models can help programmers make strategic decisions.

2.1.1 Steps to Behaviour Change

The 'Steps to Behaviour Change' model reminds programmers of the need to deliver messages in strategic manner in order to take audiences from a state of 'lack of knowledge' to one of 'sustained behaviour change' which requires specific information on services and reinforcement of the individual and social benefits of behaviour change (Piotrow et al., 1997:23). Thus, the strategy demands that BCC messages are developed based on where the audience is on the steps to behaviour change. Thus, their needs have to be identified and the appropriate message tailored to address those needs. These messages need to consider, in Nepal's context that gender, caste/ethnicity, regional identity, language and location cause differences in needs and requirements of messages.



2.1.2 Strategic Communication Approach

This communication strategy is taking an integrated approach to health for women and children, focusing on the critical time from pregnancy through the first 1000 days of a baby's life. Audience services/information needs include the following:

Life Stage Priority Area for Programming	Health Priority linked to MNCH
Newborn and Infant (first 1000 days or up to 3)	<ul style="list-style-type: none"> ▶ Newborn Care ▶ Late initiation, non exclusive and insufficient duration of breastfeeding

	<ul style="list-style-type: none"> ▶ Exclusive breastfeeding ▶ Acute Respiratory Tract Infections ▶ Diarrhoea ▶ Immunization ▶ Vitamin A Deficiency ▶ Growth Monitoring ▶ Infant and child feeding practices ▶ Underutilization of health services ▶ High reliance on traditional health practices
Adolescent	<ul style="list-style-type: none"> ▶ Nutrition ▶ Health care counselling and services ▶ Life skills
Pregnant, Delivery and Postnatal Women	<ul style="list-style-type: none"> ▶ High fertility rate ▶ Late initiation, non exclusive and insufficient duration of breastfeeding ▶ Birth Preparedness ▶ Underutilization of maternal and child health care services during ANC, delivery and PNC ▶ Nutrition and iron for Pregnant and lactating women ▶ Stop Smoking and tobacco use ▶ Malaria prevention in endemic areas ▶ Sexually Transmitted Infections/ HIV/AIDS ▶ Complication due to unsafe abortion ▶ Gender based discrimination: Work burden, harmful social norms, limited decision making power, gender based violence

To strategically address the issues across all the audiences, the Communication Strategy will use the “Nepal Pathways to Maternal, Newborn and Child Health”. The model supports the concept that social and individual behaviour change will not happen as a result of one intervention alone or by focusing on one level or segment of society, but rather through social, individual, and structural change coming together to produce a supportive society.

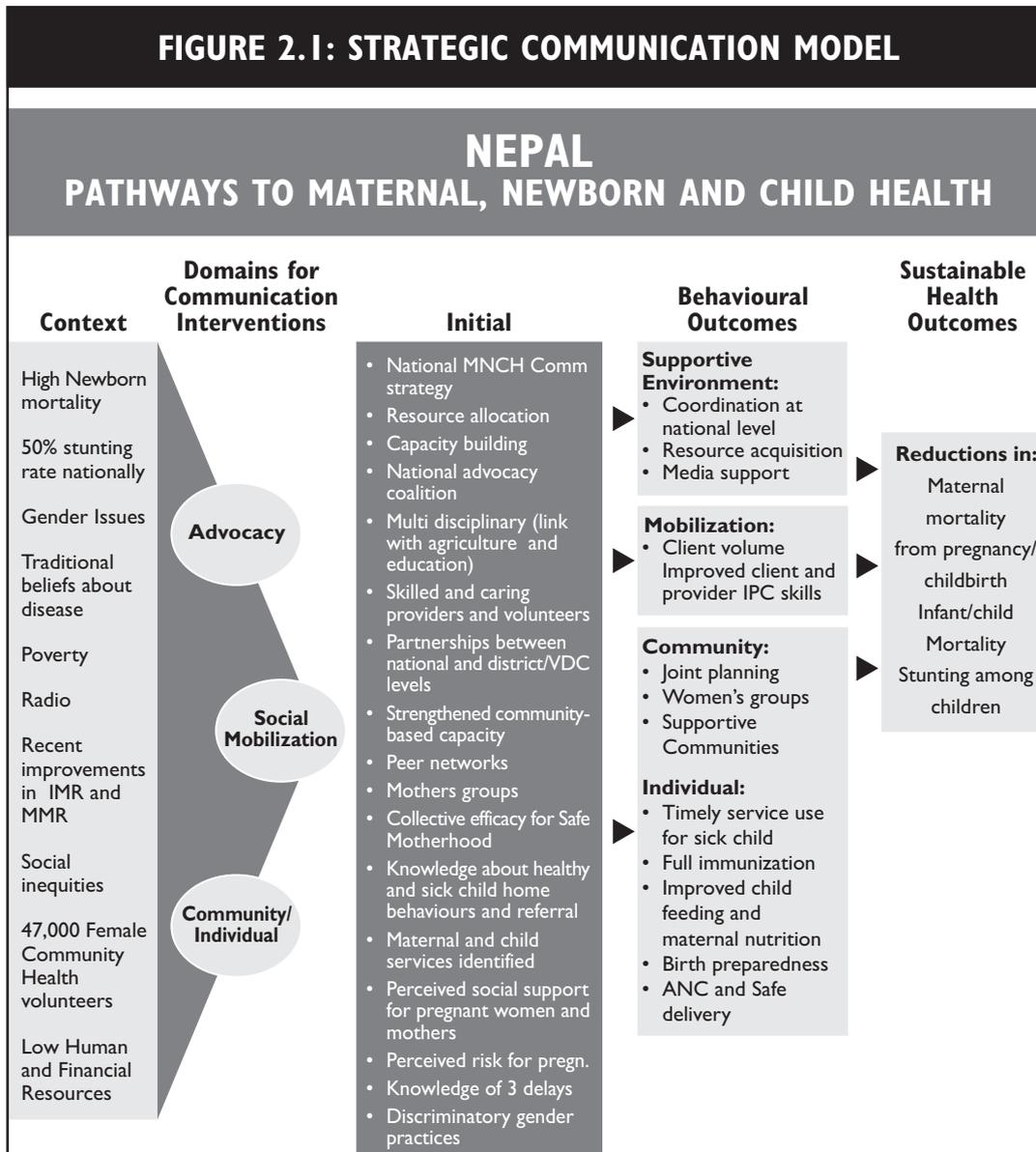
Strengthening community capacity, changing social norms, and improving specific health behaviours requires interventions at three levels of society.

- a. **Advocacy Communication** helps to create or strengthen social norms by garnering political commitment and policy change that would facilitate desired positive behaviour change. Advocacy activities will target the political leaders, policy makers and social/religious leaders at national, district and VDC level and also the I/NGO, CBOs, private sector partners and development partners. Advocacy at all levels helps to mobilize resources and services, and to accelerate the implementation of BCC programs. It also helps to cement political and social commitment to the cause
- b. **Social Mobilization Communication** is a movement at the national, district, local government and community levels, involving civil society, non-governmental organizations, community-based organizations, religious groups, and the private sector. The social mobilisation communication intends to mobilize human resources of existing networks as well as for getting support for FCHVs and health workers. The social mobilisation works through local government, NGO/CBOs, women groups, saving and credit groups, school teachers, Junior Red Cross Circle, journalists, civil society and professional organizations etc. Social mobilization communication involves the process of capacity building and intersectoral collaboration, from national to community levels to support BCC activities. Communities must be involved from the time the communication strategy is conceived to the development of interventions and through the implementation and evaluation processes. In this process the involvement of deprived, marginalized oppressed and workers population should be considered
- c. **Behaviour Change Communication (BCC)** helps individuals and communities gain the knowledge and skills and develop favourable attitudes (environment) to change or develop their own desired behaviour. BCC activities will be intended for direct right holders on rights related matters and concerned legalities such as for women, mothers, children, men's role etc and general public at large. Sometimes, FCHVs and health workers will also be the intended audience group for the BCC activities.

This conceptual framework charts -the continuum of social change across these three levels to illustrate how communication interventions lead to initial outcomes, subsequent behavioural outcomes and finally sustained health behaviours.

The Pathways Model provides the strategic organizing principle through which the communication interventions will operate to ensure synergy and consistency across all levels. This will maximize impact, resulting in sustainable health outcomes.

FIGURE 2.1: STRATEGIC COMMUNICATION MODEL



2.1.3 Strategic communication audiences

The primary audience for this strategy is mothers. These include married and unmarried, living in urban, peri-urban and rural areas, as well as hard to reach mothers who are ethnically or geographically isolated or experience caste and language based discrimination. It may be argued that other people who are in the immediate social environment are just as important to bring about change. However, the approach used in this strategy is one of empowering mothers themselves so that they can deal with their immediate environment in a more confident and active manner.

The secondary audience is composed of those people who are in the immediate environment of mothers and babies. These are the people who interact directly with mothers and babies on a daily basis and can support or block change. The tertiary audience consists of those people who define policies and govern community and overall social norms. A brief summary of the key of audiences by implementation domain are

Strategic approach	Audiences
Advocacy	<ul style="list-style-type: none"> ▶ MOHP (national, regional and district level officials and staff as well as HCP), Reproductive Health Committees, I/NGOs, EDPs and drug retailers, religious leaders, local leaders, media
Social Mobilization	<ul style="list-style-type: none"> ▶ Community-level groups, FCHVs, HWs, women's organizations, NGOs, local organizations, representative organisations of Dalits, Janajatis and other social groups. Reproductive Health Committee (district and central levels), Quality Assurance Group, District Development Committee and Village Development Committees
Behaviour Change Communication	<ul style="list-style-type: none"> ▶ Primary: pregnant women/mothers of all social groups ▶ Secondary: husbands, mothers-in-law fathers-in-law, mothers' groups, adolescents, NGOs, teachers, HFMC members, in-laws, other community members, students, health workers, traditional healers ▶ Tertiary: Community leaders (formal and informal), drug retailers, religious leaders, DDCs, VDCs, media.

2.2 OPERATIONAL AND COMMUNICATION PRINCIPLES

- ▶ **Right Based Information & Messages:**
Every woman & their family members have the right to access the information and messages on maternal, newborn and child health
- ▶ **Wider Access:**
IEC/BCC media and materials should be widely available and disseminated from central to district level to the community level, in local languages as far as possible and addressing issues which constrain women from accessing MNH services

- ▶ **Media Mix:**
Mix of media should be used to make effectiveness of and reinforce messages
- ▶ **Messages with Benefit Oriented, Consistent and Appealing:**
Messages with clear, consistent, simple and appealing to differing audiences should be developed and disseminated. The audiences must perceive the benefit of adopting the targeted behaviour
- ▶ **Localization and Inclusive:**
All IEC materials and messages will be pre-tested, decentralised, localised, inclusive and focused
- ▶ **Gender and Social Inclusion:**
Gender and social inclusion issues will be considered while implementing advocacy, social mobilization and behaviour change communication activities
- ▶ **Partnership:**
Public private partnership for communication will be encouraged and implemented
- ▶ **Coordination and Participation:**
Coordination and capacity will be strengthened at all levels for joint planning and implementation of communication activities. Audiences involvement should be maintained throughout the communication process
- ▶ **Evidence and result based programming:**
Evidence-based communication activities will be implemented, monitored and evaluated and best practices will be scaled up
- ▶ **Audience Centered:**
Audiences should be involved with a view to determine what their health needs are and participate in the process of shaping messages to address those needs
- ▶ **Service linked:**
The health promotion and communication efforts should be directed towards promotion of specific services and programs.

2.3 STRATEGIC OBJECTIVES

In order to contribute towards achieving the purpose of programme communication, the following are the main objectives of the strategy.

2.3.1 Maternal and Newborn Health

- ▶ Promoted knowledge, high self-efficacy, supportive norms, and improved maternal and newborn health behaviours in all social groups to increased institutional delivery

- ▶ Enhanced demand for and access to maternal and newborn health services among all caste, ethnic groups, disadvantaged and hard to reach population
- ▶ Strengthened mobilization of national and community resources to support birth preparedness, institutional deliveries, postnatal and newborn care
- ▶ Improve information access to safe abortion.

2.3.2 Expanded Programme for Immunization (EPI)

- ▶ Promoted knowledge of parents, families and communities about time, place and date of vaccination schedules, benefits and possible adverse events following immunization
- ▶ Strengthened understanding among mothers about the benefits of full immunization
- ▶ Enhanced demand for child vaccination services based on EPI schedules.

2.3.3 Integrated Management of Childhood Illness (IMCI)

- ▶ Promoted knowledge on childhood illness prevention and treatment of all social groups
- ▶ Enhanced demand for community-based services for child health prevention and treatment services
- ▶ Promoted knowledge and practice on hygiene and sanitation particularly hand washing with soap among mother, children and care takers of all social groups
- ▶ Increased knowledge and understanding of harmful socio-cultural practices impacting negatively to the health of newborn and children.

2.3.4 Nutrition

- ▶ Improved breastfeeding knowledge among mothers to breastfeed children exclusively for the first six months
- ▶ Promoted knowledge among mothers and families of the importance of regular growth monitoring, exclusive breast feeding (EBF), use of iodised salt and, Vitamin A
- ▶ Improved infant young and child feeding (IYCF) practices among mothers and families
- ▶ Promoted knowledge and practice on hygiene and sanitation particularly hand washing with soap among children, adolescents and pregnant women
- ▶ Enhanced knowledge of what to feed pregnant and lactating women, including iron and vitamin A

- ▶ Promoted knowledge of importance of & skills for providing local food at household level
- ▶ Promoted Knowledge of danger signs of under nutrition and when to seek care.

2.4 MONITORING AND EVALUATION OF COMMUNICATION STRATEGY

The objective of monitoring and evaluation (M & E) is to measure, analyse, interpret and report on the progress, effects, and impact of the National Communication Strategy for Maternal, Newborn and Child Health in a useful, timely and accurate manner to all the stakeholders. A strong M & E plan is needed to measure impact and outcomes tied to key objectives and specific indicators of the communication strategy. The indicators for monitoring and evaluation are mentioned in the respective chapter of the strategies.

3.1 BACKGROUND

With strong government and civic commitment and over a decade of investment, maternal mortality in Nepal declined by half between 1996 and 2006 to a Maternal Mortality Ratio (MMR) of 281 in 2006 (NDHS 2006). A point estimate of 229 maternal deaths per 100,000 live births determined in 2009 in eight districts (Suvedi et al 2009) corroborates the 2006 estimate. However maternal cause still accounts for 11 percent of all deaths of women of reproductive age, and nearly a quarter of deaths of women who die in their 20s. To reach Nepal's MDG 5 target of 134 by 2015, the MMR must continue to decline at 13 percent per year and considerable investment must be made to sustain the promising trend of reducing MMR.

A 2009 Maternal Mortality and Morbidity Study (MMM) found that haemorrhage was the leading cause of maternal death followed by preeclampsia/eclampsia, septic abortion, heart disease, obstructed labor, other direct causes and puerperal sepsis (Suvedi et al 2009). Inequities in maternal death remain: women who are under twenty or over 35, or are Muslims, Terai/Madhese and Dalits, are more at risk (Suvedi et al 2009). Also, 58 percent of women from the wealthiest quintile have skilled attendance at birth versus 8.5 percent among women in the poorest quintile.

Most women who die from maternal causes are still dying at home (42%) or in transit (12%). Also, 80 percent of woman who die from maternal causes in a hospital were in critical state upon admission. This indicates that the three delays framework detailed in the 2004 SM IEC strategy that emphasizes communication programming to address the 1) delay to seek care, 2) delay to reach care and 3) delay to receive care are still critical areas for programmatic action.

According MMR study 2009, although 78% of families recognised the seriousness of the problem, only 60% decided to seek care. Limited knowledge, difficulty in access (distance) and affordability where the main reason stated for not seeking timely care.

34 percent of maternal deaths occurred in the delivery period and up to 48 hours afterwards; and 28 percent in the pregnancy and 28 percent in

the postpartum period. The fact that 62 percent of deaths occur outside of the delivery period suggests that programming needs to consider interventions which reach women when they're pregnant and after the child is born.

Anaemia and malnutrition are underlying factors in many maternal deaths. Over one third of women who died were anaemic and over one fifth suffered from malnutrition, indicating a need for urgent action.

Neonatal deaths also declined from a Neonatal Mortality Rate (NMR) of 39 per 1000 live births (2001 DHS) to 33 (2006 DHS). However, 2011 DHS results indicate no change since 1996, so renewed efforts are needed. Neonatal deaths now contribute about 54 percent to the under five mortality and 69 percent of infants who die are neonates, and two thirds die within the first week. Nepal is on track to reach the MDG 4 target of 15 per 1000 but considerable effort must be sustained. In the recent MMM, over one-third of neonatal deaths were caused by birth injury and asphyxia, nearly 20 percent by ARI and a further 21 percent by other infections likely to include some ARI and diarrhoea. Other significant causes were low birth-weight/pre-term (6%), congenital disorders (8%), and tetanus (2%), with the remaining 10% of deaths undiagnosed.

The MMM found strong evidence of a positive response to health education messages during ANC, with some women more conscious of their well-being during pregnancy, improving their diet and not doing heavy work. However, the survey also indicated that many women do not reveal their problems till the last minute due to shyness. Also, many harmful misconceptions persist, such as poor maternal nutritional practices that dictate that a pregnant woman should eat less and work more, forbidding pregnant women to cross rivers until the labour begins or that an easy previous pregnancy means that the current one will also be easy.

The availability of safe abortion services is likely to have contributed to a reduction in the number of deaths due to abortion-related complications. The legalisation of abortion services has increased the number of reported cases, while it was not recorded previously. A recent survey implies that services are being accessed disproportionately by women who are urban (43%) and literate (74%), with only 14 percent of the sample coming from the remote and more impoverished west and far west regions. Similarly, awareness to the people need to be increased for legalization of abortion and its law provision.

Local language media and materials are not available and therefore an effort must be made to localize BCC. These interventions may require caste/ethnicity and language issues to be addressed.

3.2. PROGRAMME GOAL AND OBJECTIVE

The goal of the safe motherhood and newborn health (SMNH) programme is improved maternal and neonatal health and survival, especially of the poor and excluded.

3.3. COMMUNICATION GOAL

The goal of the SMNH communication is to contribute to increasing access to and utilization of improved maternal and newborn health information and quality services.

3.4. COMMUNICATION OBJECTIVE

The objectives of communication on SMNH are:

- 3.4.1. Increase positive attitude and behaviour of health workers and FCHVs that pregnancy, delivery and postnatal are special times for fast action to save the lives of mothers and newborns
- 3.4.2. Increase mobilization of community resources to support birth preparedness, EOC and maternal and newborn care and referral services
- 3.4.3. Increase ability of community to identify facilities for institutional delivery and EOC and skilled birth attendants
- 3.4.4. Improve interpersonal communication skills of service providers and FCHVs
- 3.4.5. Improve home based nutrition for pregnant women and adolescent
- 3.4.6. Increase knowledge and desired behaviour of community to recognize and act on maternal and newborn danger signs
- 3.4.7. Increase support for creation of an enabling environment for women's rights, to improve women's status, birth preparedness discrimination caused by gender and caste/ethnicity, regional identity, income status and location and reduced 'laaj' among women
- 3.4.8. Increase knowledge and practice on hygiene and sanitation particularly hand washing with soap among pregnant women, mother and care taker
- 3.4.9. Increase knowledge about prevention of unwanted pregnancy and safe abortion services.

3.5. AUDIENCES

The audience for communication on safe motherhood and newborn health services are identified within the three pronged strategies as given in the figure given below

Communication Strategic Approach	Audiences
Advocacy Communication	Parliamentarians, National Dalit Commission, National Women Commission, National Federation for Development of Indigenous Peoples of Nepal (NEFDIN), other Politicians and Policy makers Professional associations, Social leaders at national, regional, district and VDC levels, I/NGO NGO, CBOs and development partners, Health facility management committee
Social Mobilization Communication	NGOs, CBOs, women groups, representative organisations of Dalits, Muslims, Madhesis, Janajatis and other excluded groups, saving and credit groups, NFE instructors, School teachers, faith based leaders, Red cross circle, civil society members, Health facility management committees and
Behaviour Change Communication	<p>Primary Audience: Pregnant Women and mothers of newborn children of all social groups</p> <p>Secondary Audiences:</p> <ul style="list-style-type: none"> ▶ All other women of reproductive age, influential family members (mother in laws and husbands, close relatives) neighbours, Health Workers, Female Community Health Volunteers, social activities and leaders ▶ Mother’s groups, faith based leaders, traditional healers, community leaders

3.6. OVERVIEW OF EXISTING AND DESIRED BEHAVIOURS

In order to devise communication strategies, the following chart outlines the existing communication gaps between existing and desired behaviours. Strategies will address these gaps.

Figure 3.1
Existing and desired behaviours regarding SMNH

3.6.1. Existing behaviours (DHS/MMM)	3.6.2. Desired behaviour change
<ul style="list-style-type: none"> ▶ Only 29 % of women have all four ANC visits. 26% of women seek no ANC services at all. (DHS 2006) ▶ Half of all mothers saved for birth (54%), Only a third saved money, 9% bought a clean delivery kit and 4% contacted a health worker ▶ 29% births are attended by Skilled Birth Attendants ▶ Limited knowledge on danger signs during pregnancy, delivery and postpartum period and need for seeking care ▶ Postnatal care for mother and newborn not a priority ▶ Only 31% of women received postnatal care within two days (NDHS 2006) ▶ Limited knowledge on essential newborn care (early initiation of breast feeding, skin to skin contact after birth, bathing after 24 hours of birth) ▶ Limited knowledge on hand washing before touching or handing a newborn ▶ Limited knowledge on danger signs during pregnancy, delivery and postpartum period ▶ Limited knowledge on newborn danger signs 	<ul style="list-style-type: none"> ▶ 80% pregnant women seeks four focused antenatal care ▶ Family of all social identities, preparing (money, blood donor, transport, CDK health facility/ SBA) for birth ▶ 60% births attended by SBAs (including at least X % of births in Dalits, disadvantaged Janajatis, Madhesis and Muslims communities) ▶ Complete knowledge on danger signs during pregnancy, delivery and postpartum period and importance of quick action ▶ Correct knowledge on importance and timing of postnatal visit for mother and newborn ▶ Women receiving postnatal care increase by 20% ▶ Improve practice on essential newborn care (early initiation of breast feeding, skin to skin contact after birth, bathing after 24 hours of birth, hand washing) ▶ Improve handwashing practices before touching or handling newborn ▶ Complete knowledge on care seeking for danger signs during pregnancy, delivery and postpartum period ▶ Improve knowledge on newborn danger signs.

<ul style="list-style-type: none"> ▶ Limited knowledge about the extra-care to sick newborn ▶ Limited knowledge on nutrition during pregnancy and breastfeeding period ▶ Low use of post partum family planning ▶ Limited knowledge of Safe Abortion law and services ▶ Social norms and harmful cultural practices affecting health of women and neonates 	<ul style="list-style-type: none"> ▶ Improve knowledge about the extra-care to sick newborn ▶ Complete knowledge on adequate nutrition for pregnant women and breastfeeding mothers ▶ Increase use of post partum family planning ▶ Increase awareness and knowledge on Safe Abortion and its law, services and sites ▶ Improved social environment including family and community values and mindsets for women to access SMNH services easily.
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3.7. MAJOR TECHNICAL CONTENTS

Based on the overview of existing behaviour and desired behaviour regarding SMNH the communication strategy will emphasize the inclusion of the following contents, component wise, while developing messages for key audiences. It will ensure that the messages are tailored to the realities of different groups e.g. Dalits, Janajatis, Muslims, Madhesis and other excluded groups.

3.7.1 Antenatal Care (ANC)

Key Behaviour: A pregnant woman should have at least 4 ANC visits.

- ▶ A pregnant women and her family members should be aware of what happens during ANC visit including counselling (Blood pressure check, Abdominal examination to assess baby's condition, Iron tablet, TT injection, De-worming tablets and nutrition)
- ▶ Every family identifies an SBA and health facilities and know birth preparedness (money, transport and blood donor) and emergency readiness and prepares accordingly.
- ▶ The following life threatening danger signs during pregnancy: bleeding, swelling of hands and face, fever or foul- smelling discharge from vagina and fits, convulsions or loss of consciousness
- ▶ Insecticide treated bed net should be used to prevent mosquito bites in malaria endemic areas

- ▶ If a pregnant woman has difficulty seeing at night, she should contact a health worker
- ▶ Inform pregnant women about transmission of HIV from infected mother to child during pregnancy, delivery, and breastfeeding
- ▶ Information about free maternity services delivery (including caesarean sections), available services and Aama programme including safe delivery incentive programme.
- ▶ Safe abortion law, available options, services and government listed service sites at the district and community level.
- ▶ Work burden of women needs to be shared by other family members so that she can rest and also find time for ANC visits

3.7.2 Delivery Care

Key Behaviour: Delivery to be conducted by a Skilled Birth Attendant (Doctor, Staff Nurse or ANM)

- ▶ Knowledge on danger signs (bleeding, prolonged labor, fits, convulsions or loss of consciousness) during delivery and where to go
- ▶ Every delivery should take place in a health institution. Family has to ensure that pregnant woman reaches health facility on time, pregnant woman has to be prepared to go and in fact must demand for it
- ▶ Influential family members must be convinced of the need to go to a health institution for child delivery
- ▶ Prepare one person to take care of newborn at the time of birth and where to go if a danger sign is seen. Please consult the nearby FCHVs for immediate care and get appropriate advice
- ▶ Home remedies for treatment of sick newborn if being tried should be done with the knowledge of FCHVs
- ▶ Families must not delay too much before taking medical advice for treatment of sick child
- ▶ Inform about safe delivery incentive and free delivery (including caesarean sections) services for pregnant woman and promote birthing centre for delivery.

3.7.3 Post Natal Care (PNC) for mother and newborn

Key Behaviour: Woman should have three PNC visits (within 24 hours, 3rd and 7th day) with a health worker

- ▶ Couple should seek FP counselling and services after delivery and after abortion
- ▶ Knowledge on danger signs during postnatal period and where to go (bleeding, high fever, fits, convulsions or loss of consciousness)
- ▶ Nutritional food and postnatal vitamin A for postnatal mother.

Key Behaviour: Women and caregivers should know and practice 5 aspects of Essential Newborn Care

- ▶ Five Essential Newborn Care Practices are (1) clean baby with soft, clean and wrap the baby with dry and soft clothes immediately after birth, 2) keep baby skin to skin touch in mother chest (mayako angalo) 3) keep umbilical cord clean and dry, 4) start breast feeding within one hour of birth, 5) bathe only after twenty-four hours of birth
- ▶ Danger signs of Newborn : fast breathing , severe chest indrawing, unable to breastfeed, fever, hypothermia, skin pustules, umbilicus pus or red to skin and lethargic or unconscious)
- ▶ FCHVs can assess (and can start the treatment at few districts of) sick newborn. Please consult the nearby FCHVs for immediate care and get appropriate advise.

(For detailed information on nutrition, please see section 6 Nutrition Strategy)

3.7.4 Safe abortion care for women with unwanted pregnancies

Key Behaviour: Women seeks safe abortion care from trained, listed provider in listed health institution with contraceptive knowledge

- ▶ Use contraceptive methods for preventing unwanted pregnancies
- ▶ Use post abortion contraceptive methods for preventing unwanted pregnancies
- ▶ Legal provision of safe abortion and penalties and punishment for its violation
- ▶ Importance of using trained and listed health workers and listed health institutions
- ▶ Service availability and listed sites.

3.8. COMMUNICATION STRATEGY

The strategic design for communication programme on safe motherhood and newborn health will be through three mutually reinforcing approaches: advocacy communication, social mobilization communication and behaviour change communication/IEC linked with SMNH services.

3.8.1 Advocacy

Advocacy communication will be carried out among the tertiary audience, such as parliamentarian, other politician, leaders, policy and decision-makers, External Development Partner (EDP), program managers and sectoral line agencies, health facility management committee.

- a. Continue Safe Motherhood Newborn Health Subcommittee for improved coordination and collaboration in Safe Motherhood and Newborn planning, implementation and monitoring. This group will strengthen knowledge management so that strategies and programme research implementation and monitoring materials can be accessed electronically
- b. Advocate for political and social commitment for resources allocation and equitable distribution of skilled human resources and health facilities for SMNH at all level
- c. Advocacy with media to increase coverage of SMNH programmes.

3.8.2. Social Mobilisation

Social mobilization activities are important for ensuring the involvement of people at all levels to obtain support for care of mother and newborn. Social mobilization activities will be conducted to mobilize resources and improve service coverage at the district and community level.

- a. Strengthen networking, communication and monitoring skills to help organizations and government institutions implement quality SMNH programmes. These activities will help districts and VDCs implement the recent policies which mandate using a certain percentage of their funds on programmes for women and children. Conduct BCC trainings as needed in different languages and addressing local issues constraining access to SMNH services of women of different communities
- b. Work with women's groups and representative organisations of Dalits, Janajatis, Muslims, Madhesis and other excluded groups to communicate the key messages of good SMNH behaviour and action in their constituencies, addressing the specific issues of that community
- c. Strengthen Health Facility Management Committees to prioritize maternal and newborn health, monitor who is accessing services and who is not, identifying the constraining causes as well as take critical actions to improve health services.

3.8.3 Behaviour Change Communication (BCC)

BCC will inform people about SMNH and bring about positive change in individual and community behaviours.

- a. **Strengthen Individual and Group Interactions between FCHVs/Service Providers and women.** Interpersonal communication between a woman or family and their FCHV/provider has been shown to have impact on behaviour change when they meet individually or in a group. And yet, behaviour change is difficult and the FCHVs are tasked with reaching out to those who still resist practicing improved behaviours. This communication strategy proposes supporting and strengthening the FCHV's BCC interactions through new interactive methods and fresh communication approaches. Communication messages will address caste or language based barriers in case specific groups of women are unable to access FCHV's services due to such reasons
- b. **Entertainment-education through mass media.** Develop a new multimedia campaign (radio, television and folk drama with song) to reach out to women and communities. This programme should be research- and theory-based to help mothers and their families overcome the considerable barriers to improved outcomes. According to the 2006 DHS, a distance education for FCHVs was the only radio programme to have an impact on increasing skilled attendance at birth. Develop a new radio or audio-based distance education programme for district and VDC level managers and service providers and FCHVs to motivate them and strengthen their ability to provide quality services through health updates, Q and A, drama role modelling improved IPC, competitions, etc. Programmes should use fresh and innovative formats that bring in elements of reality programming, audience participation and as specific as possible to address the local contexts and local barriers of women in accessing services through and traditional entertainment practices. Also, the programmes could be broadcast over community FM, radio through mobile phones or on CD/tape. Entertainment programme should organise in the major festivals and social events where lot of general public are participating
- c. **Link with NFE and other literacy programmes and community mobilization initiatives.** The MMM strongly linked literacy with improved maternal and newborn health outcomes, therefore a programme strategy will be to include maternal and newborn health content into the existing NFE curriculum and different community group discussion and social interaction
- d. **Reach out to men and mothers in law.** Develop new programs to solicit husband and mother in law support to women to completing required member of ANC visits, institutional delivery and for birth preparedness. and act accordingly. Design a process of sustained dialogue with men and other influential family members to discuss gender based discrimination e.g. workburden of women, lack of care, lack of nutritious food, frequent

pregnancies, lack of women's voice and decision-making power, violence against women and the impact of such social norms on SMNH

- e. **Develop new programmes that harness mobile technology.** Test and then scale up programmes for women and families that utilize mobile technology such as free daily texts for pregnant women or special emergency mobile phones for pregnant women. Teach FCHVs to ensure that women are able to read such texts.

3.9. COMMUNICATION ACTIVITIES

For the implementation of the communication strategies on SMNH some activities need to be carried out. The section lists strategy wise activities to be carried out by the national and district level concerned agencies particularly NHEICC and DPHOs.

3.9.1 Advocacy

- a. **Clarify research.** Assess existing research available and identify gaps. Carry out formative researches on SMNH at national and selected districts (covering various ecological regions of the country and different caste, ethnicity and regional identity groups and Muslims) to identify communication gaps, needs, suitable media and behavioural causes associated with three delays. Results can be used for preparing advocacy toolkits, and communication messages and deciding appropriate media for social mobilization and BCC on SMNH
- b. **Preparation of advocacy toolkits.** Prepare evidence-based advocacy kits to reach out to national and local level government and development partners for technical and resource assistance and political and social commitment for SMNH. Some key issues are 1) Ensuring adequate human resources at all levels 2) Raising the profile of MNCH as a priority for action 3) Public and social audit to make sure the local government resources designated for women and children are being used appropriately 4) Reinstatement of the Health Education Technician (HET) post - a person wholly dedicated to Health Education activities at the district level
- c. **Conduct Advocacy activities:** Use advocacy toolkits to facilitate dialogue with parliamentarians, policy makers, development partners, and professional association members and network to seek commitment at national, district and community level policy and decision makers and to get technical, political and managerial support including resource allocation for SMNH services including communication services
- d. **Orientation for media:** Develop press kits and then hold sensitization seminars for national and local level media (radio, TV, local FM, newspaper)

representatives to increase coverage of SMNH programmes and issues in their respective media.

3.9.2 Social Mobilization

- a. **Strengthen BCC skill linked to SMNH during annual planning meetings at regional or district levels.** The government already holds annual planning meetings. Strengthen national and district level behaviour change communication skills and ability to analyze data at the district level and below and make informed decisions on how to identify and address the situations in each of their districts using localized communication. Also, the district and local levels will be strengthened in programme monitoring and feedback mechanisms and linkage must be established with on-going processes in the district
- b. **Toolkit for district and VDC decision making about SMNH.** Each district and VDC has a section of their budget designated for maternal and child health. But, most do not have the ability to make informed decisions about the best direction for their local programme that will garner the greatest impact for their mothers and children. NHEICC and partners will develop a 'toolkit for local decision making'. The NHEICC can also assist Regional Health Training Centers to orient the district staff and NGO workers on the use of such toolkits. Local mechanisms like Ward Citizen's forum (established through Ministry of Local Development), Integrated Planning Committee (IPC established at VDC levels for planning) must be used for communication
- c. **Organize social mobilisation events:** The NHEICC at centre and D/PHO at district and health facility at VDC level work together with different stakeholder to celebrate international and national events like: international women's day as safe motherhood day, by organising mass gathering, rallies, communication events, inter school, group competitions to promote safe motherhood and the importance of public support for programme operation.

3.9.3 Behaviour Change Communication (BCC)

- a. **Prepare materials on SMNH :** Based on information generated from the formative research, prepare new interactive materials such as pictorial booklets, story books, comic books, videos, music videos, NFE curricula, Short Message System (SMS) messages, etc that incorporate messages on preparation for birth (delayed marriage, delayed child bearing), promote improved nutrition, antenatal care, delivery care, postnatal care, newborn care, family planning, safe abortion, prevention (PMTCT) of HIV/AIDS transmission to be used by the health workers and volunteers in clinics or communities

- b. Develop new communication activities and materials for men and mothers-in law:** Men and mothers-in-law are key decision makers. Reach out directly to these audiences with attractive campaigns that encourage their participation to take care of the family by knowing the facts about how to keep the mother and the baby safe and healthy, including actions related to maternal nutrition, breastfeeding, complication readiness, birth planning, etc
- c. Supporting FCHVs with innovative communication approaches and interactive SMNH Kit:** After reviewing existing Birth Preparedness Package and Community-based Newborn Care Package, develop supplementary interactive activities for FCHVs and health workers to help them reach out to women and families especially for marginalized and underserved communities. These could be games with cards, story telling, songs, etc. Train FCHVs in these new methods
- d. Strengthen provider and FCHV skills** on BCC process and interpersonal communication skills and to develop their skills on utilization of mixed communication media (interactive group meeting, interpersonal communication channels, mass media and traditional media) to reach the primary audience
- e. Organize mass communication campaign activities:** National and district level government and NGO partners will organize radio programmes, television programmes, rallies and campaign activities to raise the profile of the SM issues. Activities will coincide with Teej, International Women's Day, local festivals (such as Ghora), market days or other events. The mass activities can include street dramas, health fairs, people talking who have lost a loved one to a maternal or newborn death, flash mobs, healthy baby competitions, etc. These events can be filmed and used for later social mobilization or advocacy activities. Appropriate IEC materials will be developed, produced and disseminated for this campaign
- f. Harness the power of using mobile phone:** NHEICC and partners will investigate how to use mobile phone in their approaches to strengthening the health communication system and approaches to reaching women and community members with motivating and supportive information by reviewing both Nepal specific and global experience with such programmes
- g. Hold community interaction and orientations about SMNH** among key community members, including key social and religious leaders. Develop guidelines for community interactions and orientation
- h. Mobilise/use mass media** at national, district and sub-district levels such as radio and TV dramas and spots. Coordinate with DHOs and disseminate success stories of women whose lives have been saved.

3.10. MONITORING AND EVALUATION

Monitoring and evaluation of implementation and results of SMNH communication strategies will be carried out regularly as well as periodically. The NHEICC will monitor the communication activities from the national level and the DPHOs will do the same at district and sub-district and community level. Necessary information will be solicited from the regular HMIS data and periodic survey data.

Though it is difficult to monitor and evaluate the direct effects and impact of communication strategies, some strategy wise indicators will be used as milestones for this purpose. The following are some of such indicators which will be used for monitoring and evaluation.

3.10.1 Indicators

- a. Percentage of women and families who can identify maternal danger signs
- b. Percentage of women and families who can identify newborn danger signs
- c. Percentage of women who can identify where to access maternal and newborn health services from an institution or service provider
- d. Percentage of women and families who know the Essential Newborn Care Practices
- e. Percentage of women and families who know that abortion is legal and where to access services
- f. Percentage of women and families who know the importance of time interval of four focus ANC visits
- g. Percentage of pregnant women with at least 4 ANC visits
- h. Percentage of women and families who have planned for birth by saving money, arranging transport, arranging blood and identified an SBA
- i. Percentage of births attended by SBA or in health facility
- j. Percentage of mothers with 3 Postnatal Care check ups by SBA or a trained health worker after delivery
- k. Percentage of mothers who received Vit A capsules within 6 weeks after delivery
- l. Percentage of mothers practicing immediate and exclusive breast feeding
- m. Percentage of women and families who practice Essential Newborn Care.

4.1. BACKGROUND

Globally data revealed that more than 70% of deaths in under five children were due to five common conditions: respiratory infections, malaria, diarrhoea, malnutrition and measles. CB-IMCI addresses those five major killer diseases in a holistic manner because 3 out of 4 children who seek health care are suffering from one of the five common childhood disease conditions, and more often than not, suffer from more than one condition. CB-NCP addresses the causes of neonatal mortality due to infection, low birth weight, hypothermia and birth asphyxia. For CB-IMCI/NCP an enabling environment is created at the community level through rapport building and sharing of information, followed by training and orientation for health workers, community health workers (VHWs, MCHWs and FCHVs). These cadres are then mobilized to provide CDD, ARI, nutrition, immunisation, and neonatal care in communities.

NDHS 2006 indicated that the service utilization at health facilities and among community level health workers and volunteers was low. Perceived gaps in maintaining the quality services of newborn interventions at community level and problems with monitoring and supervision on CB-IMCI/NCP programme. The above identified gaps demand the development of a comprehensive BCC/social mobilization plan to promote care seeking behaviour during child diarrhoea, pneumonia, malnutrition, measles and newborn illness.

There is need to strengthen the coordination among stakeholders to carry out various BCC and social mobilization activities, promote public private partnership. and mobilization of community level support groups e.g. mothers group, child clubs and other saving and credit groups for creating awareness about the programme and promotion of essential newborn care.

4.2. PROGRAMME GOAL AND OBJECTIVES

The goal of the programme is:

To contribute towards improving child health, survival, healthy growth and development; and reduce the morbidity and mortality of under five children of Nepal.

The objectives of the programme are:

- 4.2.1. Improve coverage and case management skills of health workers including interpersonal counselling skills
- 4.2.2. Improve case management of childhood illness
- 4.2.3. Improve family and community practices in relation to child health for focusing on prevention, early referral and management of sick newborn and children under five years of age.

4.3. COMMUNICATION GOAL

The goal of communication is to increase knowledge and improve practices that contribute to the reduction of morbidity and mortality by improving health, survival, growth and development of under five children of Nepal.

4.4. COMMUNICATION OBJECTIVE

The specific objectives of communication strategy are to:

- 4.4.1. Increase the knowledge of safe behaviours for the prevention of newborn and childhood illness among mothers and care takers of different communities including, Dalits, Adibasi Janajatis, Muslims and other excluded groups
- 4.4.2. Increase practices and promotion of safe behaviours such as hand washing with soap for the prevention of newborn and childhood illnesses among mothers and care takers
- 4.4.3. Increase demand for services in all social groups for newborn and childhood illnesses
- 4.4.4. Increase practices of home treatment for newborn and childhood illnesses promoting indigenous practices which are beneficial
- 4.4.5. Ensure an enabling environment for IMCI through community and family support for safe behaviour related to newborn and childhood health.

4.5. AUDIENCES

The audience segmentation is as follow:

Strategic Communication Approachs	Audience Category
Advocacy Communication	Policy makers - Child Health Division, FHD, NHEICC, NHTC, LMD, political and social leaders, RHD, DHO at national, regional district

	and VDC levels, I/NGO, media and development partners, Ministry of Agriculture, Municipalities and DDC with Water, Sanitation and Hygiene activities
Social Mobilization Communication	NGO/CBOs, women groups/health mothers groups, saving and credit groups, school teachers/students, Junior Red Cross Circle, child clubs, media, VDC/HFOMC civil society and professional organizations, representative organisations of excluded social groups, Women and Children Organization and Municipalities
Behavioural Change Communication	Primary - Mothers/caretakers Secondary: Fathers, other family members, neighbours, FCHVs, Health Service Providers and health mothers group members

4.6. OVERVIEW OF EXISTING AND DESIRED BEHAVIOUR

The IMCI communication strategy is based on the behaviour analysis, below.

Figure 4.1

Existing and desired behaviour regarding childhood illness and newborn health

4.6.1. Existing behaviours	4.6.2. Desired behaviour change
<p>Mothers and Caregivers</p> <ul style="list-style-type: none"> ▶ Mothers have limited knowledge about danger signs of respiratory infections, malaria, diarrhoea, malnutrition, measles and newborn's danger signs ▶ Mothers have limited knowledge of how to manage diarrhoea and ARI at home ▶ Mothers are not adequately aware of seeking health services to treat their newborns and under 2 months young infant when they are sick 	<p>Mothers and Caregivers</p> <ul style="list-style-type: none"> ▶ Mothers have full knowledge on danger signs of respiratory infections, malaria, diarrhoea, malnutrition, measles and newborn's danger signs ▶ Mothers are able to manage diarrhoea and ARI at home ▶ Mothers will follow the four home rules to treat diarrhoea at home

<ul style="list-style-type: none"> ▶ Mothers have limited knowledge on complimentary food ▶ Mothers and families do not give fluids and food during diarrhoea ▶ Limited use of ORS and Zinc ▶ Poor hygiene and sanitation practices ▶ Gender based discriminatory practices of neglecting girl child ▶ Patriarchichal division of labour leading to social acceptance of only mother as the child care giver and keeping father away from such responsibility <p>Health Workers</p> <ul style="list-style-type: none"> ▶ Service providers have inadequate interpersonal communication skills. 	<ul style="list-style-type: none"> ▶ Mothers and caretakers are able to give home therapy during ARI ▶ Mother are seeking health services to treat their under 2 months young infant whenever needed ▶ Mothers have complete knowledge on age specific complimentary food ▶ Mothers and families are giving fluids and food during diarrhoea ▶ Mothers are using ORS, Zinc for diarrhoea with the knowledge of coverage and compliance at home ▶ Mothers/care seekers practice improved hygiene and sanitation practices particularly hand washing with soap <p>Health Workers</p> <ul style="list-style-type: none"> ▶ Service providers have improved interpersonal communication skills.
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4.7. MAJOR TECHNICAL CONTENTS

4.7.1 Hygiene and Sanitation

Key Behavior: Wash hands with soap during six critical times

- ▶ Wash hands with soap and water during six critical times (1) after defecation, 2) before preparing meals or before feeding children, 3) after cleaning a child's bottom, 4) before eating, 5) after disposing children's faeces 6) before touching newborn
- ▶ Use safe drinking water purify using chlorine, boiling, filtering and sodis)
- ▶ Keep water and food covered with clean utensils
- ▶ Always use toilet for defecation

4.7.2 Diarrhoea

Key Behaviour: Recognise and seek treatment from HF if see signs of severe dehydration and dysentery

- ▶ Diarrhoea - If a child has watery stool more than 3 times a day then the child has diarrhoea. Start home treatment, Use latrines and dispose faeces safely
- ▶ Danger signs of dehydration (lethargic or unconscious, unable to drink /breast milk, skin pinch very slow, sunken eyes)
- ▶ Four home rules to treat diarrhoea at home
 1. Increase intake of home fluids like dal, starch, soup, clean and safe drinking water and frequent breast feeding
 2. Continue frequent feeding as usual and give extra one meal for at least two weeks
 3. Zinc treatment should be given once a day for ten days with ORS
 4. Consult FCHV for free ORS and zinc
- ▶ Seek treatment at health institution if many times watery stool, repeated vomiting, fever, blood in stool, poor eating and drinking, thirsty
- ▶ Recognise and seek treatment from health institution for some or severe dehydration and dysentery immediately
- ▶ ORS and Zinc is provided free by FCHV/VHW/MCHW or HF or can be procured at private pharmacies
- ▶ Where to get services.

4.7.3 Pneumonia

Key Behaviour: Care seeking if sign of pneumonia is seen in child

- ▶ Recognise the danger signs for severe pneumonia such as chest indrawing, unable to breastfeed or drink, lethargic or unconscious or convulsion
- ▶ If child has fast breathing, it is pneumonia. Pneumonia should be immediately treated either by FCHVs or HWs. Fast breathing means 50 or more breath/minute for child from 2 months-5 years and 60 or more/minutes for infant less than 2 months
- ▶ If there is only common cold, it can be managed at home (Home care: check for fast breathing or chest indrawing, give more fluids, frequently breastfeed, clean the nose, keep the baby warm, give frequent feeding). Consult FCHVs immediately for further care
- ▶ Promotion of using smoke free "chulo" at home and tobacco smoke free home
- ▶ Breast feeding, warm environment, timely immunization, nutrition, hygiene
- ▶ Free treatment and where to get services.

4.7.4 Malaria

Key Behaviour: Care seeking if sign of malaria is seen in child

- ▶ Use insecticide treated bed net in malaria endemic districts, especially among pregnant women
- ▶ Take the child to health facility in any fever except common cold case in malaria endemic districts
- ▶ Free treatment and where to get services.

4.7.5 Measles

Key Behaviour: Care seeking if sign of measles is seen in child

- ▶ Measles is major infectious disease in under five children. A child having fever with generalised skin rashes should be taken to health workers for diagnosis and treatment
- ▶ Measles is transmitted from droplet, therefore, keep healthy children and infected children separately
- ▶ Consult health workers immediately with the appearance of any signs and symptoms of measles in children
- ▶ Bring your child to FCHV/HF for vit A supplementation
- ▶ Your child must be immunized against measles after completion nine months. Bring your child to the nearest EPI clinic for free immunization
- ▶ Where to get services and immunization and measles treatment.

4.7.6 Newborn Care

Key Behaviours: Mothers and caregivers will practice five essential newborn care behaviours

- ▶ Five Essential Newborn Care Practices are (1) clean baby with soft, clean and wrap the baby with dry and soft clothes immediate after birth, 2) keep baby skin to skin touch in mother chest (mayako angalo) 3) keep umbilical cord clean and dry, 4) start breast feeding within one hour of birth, 5) bathe only after twenty-four hours of birth
- ▶ Danger signs of newborn: fast breathing, severe chest indrawing, unable to breastfeed, fever, hypothermia, skin pustules, umbilicus pus or red to skin and lethargic or unconscious)
- ▶ FCHVs can assess and can start the treatment of sick newborn, where newborn care program introduced. And please consult the nearby FCHVs for immediate care
- ▶ Go for institutional delivery and in case of home deliveries, importance of clean delivery practices and the presence of a SBA at home deliver
- ▶ Where to get newborn care services.

4.8. COMMUNICATION STRATEGY

The programmes work to improve the case management skills including interpersonal counselling of health-care staff, contribute towards strengthening overall health systems and improving family and community health practices for prevention, promotion, early referral & treatment of childhood illnesses.

4.8.1 Advocacy

The objective of conducting advocacy communication will be to gain support for maintaining quality of CB-IMCI services, expansion of CB-NCP programme, formulation and revision of policy/strategies by receiving political, managerial and social commitment as well as resources for the programme.

- a. Continue the IMCI technical group which coordinates IMCI programmes nationally among government and INGO Partners. Consider adding other working members who have expertise in communication
- b. Solicit adequate resources for CB-IMCI/NCP programme communication and support to implement and monitor the programmes at various levels
- c. Develop appropriate policies and guidelines for regular functioning and strengthening health services through communication.

4.8.2 Social Mobilisation

Social mobilization communication will be used for ensuring the involvement of people at all levels to obtain support for increasing the utilization of CB-IMCI/NCP services from Health Facility and community level health worker for newborn/under five children.

- a. Continue district level micro-planning where all partners at the district level jointly plan for effective implementation especially in low performing districts
- b. Mobilizing human resources of existing networks as well as for getting support for FCHVs and health workers especially for identifying and reaching the hard to reach population in order to sustain the implemented CB-IMCI/NCP programmes up to community level.

4.8.3 Behaviour Change Communication

- a. Reach women and caretakers with the knowledge required through IPC and mothers group meetings with FCHVs
- b. Use a variety of media, including mass media, IPC, traditional folk media to reach mothers, family members, FCHVs and people at large to bring about desired changes in their KAP regarding childhood illnesses and newborn services and care

- c. Ensure appropriate materials for mothers/caregivers are available at the health facility and other community level outlets
- d. Strengthen interpersonal communication skills of FCHVs and other health workers to be more able to share information effectively and motivate women and caretakers to practice new behaviours.

4.9. COMMUNICATION ACTIVITIES

4.9.1 Advocacy

- a. **Continue the IMCI technical group** to coordinate IMCI programmes nationally and at the local level among government and INGO Partners. Consider adding other working members who have expertise in communication, if appropriate
- b. **Make an advocacy plan** for increasing financial resources for new communication materials, media and methods. This will include contact with key policy makers to ensure commitment. Review existing policies and determine plans. Develop advocacy toolkit based on need
- c. **Journalists.** Advocate for CB-IMCI/NCP promotion with journalists in the print and electronic media
- d. **Research.** Review existing behaviour data, communication gaps, needs, media preferences and BCC materials at the national and district levels and determine if further desk review or independent research is needed for developing new or improved materials
- e. **Media Orientation.** Organize orientation/sensitization meeting or seminar for national and local level media (radio, TV, Local FM, newspaper) representatives to have maximum coverage of programmes and issues in their respective media.

4.9.2 Social Mobilization

- a. **Group meetings for coordination:** NHEICC at central, the DPHO at district, health facilities at local level organize group meetings with community groups, volunteers, women groups, CBOs to solicit support of community and women group
- b. **Capacity Strengthening in Communication at District Level.** Ensure Communication participation in district micro planning
 - i. Review existing skills and needs for communication training and prepare curriculum as needed
 - ii. Prepare curriculum to provide training on communication to DDC, VDC, women's group, and FCHVs to be able to carry out their tasks

of educating and assisting women for CB-IMCI/NCP especially for marginalized and underserved communities. Assist district level trainers to train the FCHVs

- c. **Organize mass communication major events.** The NHEICC at central, and the DPHO at district level organize safe motherhood and child and newborn related programme events.

4.9.3 Behaviour Change Communication activities

- a. **Review existing materials** being used by FCHVs and other community mobilizer and determine gaps. Develop new print or audio-visual materials if needed. Some ideas for new materials may include interactive games, stories, new curricula for group discussions, playing songs or shows over mobile and discussion, linking with radio programme
- b. **FCHV Capacity.** Review FCHV and community mobilizer IPC skills, determine gaps. Adapt existing or develop new communication interactions to support training
- c. **Orient health workers** on BCC process and to develop their skills on utilization of mixed communication media (interactive group meeting, SMS, interpersonal communication channels, mass media and traditional media)
- d. **Review and print existing communication materials:** Reprint/copy or develop new communication materials (resource booklet, brochure, leaflet, story booklet, flip chart, poster, and audio visual etc.) for facilities. The Birth Preparedness Package will be adapted and modified for the CBNCP. It will be used for interpersonal and group education through mothers' groups and one on one communication by FCHVs, SBAs and other health staff in NCP introduced district
- e. **For an enabling environment at the community level**
 - i. Hold community orientations about IMCI among key community members, including key social and religious leaders. Develop guidelines for community interactions
 - ii. Use mass media at national, district and local levels such as radio and TV dramas and spots. Coordinate with DHOs and showcase success stories of children whose lives have been saved because they followed CB-IMCI best practices.

4.10. MONITORING AND EVALUATION

4.10.1 Indicator for Advocacy

- ▶ Quarterly programme monitoring from national level

- ▶ Presence of technical guidance and advocacy to all stakeholders at national, region and district levels
- ▶ Percent of resource allocation for IEC/BCC under CB-IMCI/NCP programme
- ▶ Number of news items released in print or electronic media.

4.10.2 Indicator for Social Mobilization

- ▶ Proportion of communication resources allocated for hard to reach, marginalize /disadvantage and vulnerable population through micro planning process
- ▶ No. of events organized.

4.10.3 Indicator for Behaviour Change Communication (BCC)

Mothers and caregivers

- ▶ Percentage of mothers/caregivers who have complete knowledge on danger signs of diarrhoea
- ▶ Percentage of mothers/ caregivers using ORS, zinc and home fluids to treat diarrhoea treatment at home
- ▶ Percentage of mothers/caregivers with knowledge on ARI danger signs
- ▶ Percentage of mothers/caregivers seeking treatment for ARI/pneumonia
- ▶ Percentage of mothers/ caregivers who have complete knowledge of five essential newborn care behaviours
- ▶ Percentage of mothers/ caregivers who practice \ five essential newborn care behaviours
- ▶ Percentage of mothers/care givers who have knowledge of newborn danger signs
- ▶ Percentage of mother/caregivers seeking health services to treat their sick children
- ▶ Percentage of mothers/care takers washing their hands with soap and water at critical times
- ▶ Percentage of use of bed net in malaria endemic districts
- ▶ Percentage of any fever case taken to health facilities in malaria endemic districts.

5.1. BACKGROUND

Expanded programme on immunization (EPI) has proved to be one of the most cost effective public health interventions in child survival. Universal immunization of children against vaccine preventable diseases-

- ▶ Tuberculosis,
- ▶ Diphtheria,
- ▶ Whooping cough,
- ▶ Tetanus,
- ▶ Hepatitis B
- ▶ Polio,
- ▶ Measles and Rubella,
- ▶ Hemophiles influenza (Hib)

Hemophiles influenza is crucial in reducing infant and child mortality. Along with the provision of vaccines, vaccinators and supplies, application of behaviour change communication strategy is important to reach the caretakers, children and ensure utilization of the immunization services for optimum coverage.

The EPI coverage is currently high. In the recent 2011 DHS, nearly nine in ten children (87%) were fully immunized and 96 per cent of children received BCG, DPT 1 and Polio 1. Given this high rate, programmers are focusing on maintaining that rate and giving intensive efforts to reach the families who are not fully immunized. Children in the Terai are less likely to be fully immunized than children in other zones (84%). There is a growing concern that the coverage is going down in the recent couple of years. Also, immunization coverage has always been a problem. Some of the issues in immunization are:

- ▶ Inaccurate population estimates
- ▶ Mobile and migrant families
- ▶ Lack of urban health care facilities and system for public health
- ▶ Interpersonal communication challenges
- ▶ Lack of awareness among hard to reach population

5.2. PROGRAMME GOAL AND OBJECTIVES

The programme goal is to reduce child mortality, morbidity and disability associated with vaccine preventable diseases

The objectives of the National Immunization programme are to:

- ▶ Achieve and maintain at least 90% vaccination coverage for all antigens both at national and district level by 2016
- ▶ Ensure access to vaccine of assured quality and with appropriate waste disposal
- ▶ Achieve and maintain polio free status
- ▶ Maintain maternal and neonatal tetanus elimination status
- ▶ Achieve measles elimination status by 2016
- ▶ Accelerate control of vaccine-preventable diseases through introduction of new and underutilized vaccines
- ▶ Expand VPD surveillance
- ▶ Continue to expand immunization beyond infancy.

5.3. COMMUNICATION GOAL

The goal of the communication is to increase knowledge of women, parents and caretakers about the benefits of immunization and to encourage completing all required immunization as per government immunization schedule.

5.4. COMMUNICATION OBJECTIVES

The communication objectives are to:

- 5.4.1 Increase knowledge of parents, families and communities about time, place and date of vaccination schedules and benefit of immunization focusing on hard to reach population
- 5.4.2 Increase attendance of parents and other caretakers to vaccinate children as per EPI schedule
- 5.4.3 Enhance IPCC skills of service providers to motivate parents and caretakers
- 5.4.4. Secure inter-sectoral support for immunization programmes through advocacy.

5.5. AUDIENCES

The audience segmentation for communication on promotion of use of EPI can be charted by various approaches of communication strategy as follow:

Strategic Communication Approachs	Audience Category
Advocacy Communication	VDC leaders, political leaders, teachers, CBO/NGO, media, women's groups, Department of Health services, Ministry of Local Development, Ministry of Education, Ministry of Women, Children and Social Welfare, Health Management Committees, professional associations like NEPAS, NMA, NAN, NESOG, PESON, Paramedics, PBSON/NPABSON, Red-Cross, Rotary etc
Social Mobilization Communication	NGO/CBOs, women groups/health mother groups, saving and credit groups, school teachers, Red Cross Society, Rotary, Junior Red Cross Circle, child clubs, youth clubs, media,VDC/HFOP, religious leaders, civil society and professional organizations, FCHVs etc
Behavioural Change Communication	Primary: Mother, Fathers and care givers Secondary: Grand parents, Siblings and other family members, students and teachers.

5.6. OVERVIEW OF EXISTING AND DESIRED BEHAVIOUR

Figure 5.1
Existing and desired behaviour regarding EPI

5.6.1. Existing behaviours	5.6.2. Desired behaviour change
<ul style="list-style-type: none"> ▶ 4% of primary care givers don't bring children for immunization as per recommended schedule ▶ 13% of primary care givers do not complete full immunization ▶ Primary care givers have limited knowledge about age specific immunization schedule and benefits ▶ Migrants parents not aware of immunization time, place and date 	<ul style="list-style-type: none"> ▶ Primary care givers bring their baby for immunization as per recommended schedule ▶ Primary care givers seek full immunization for their child ▶ Primary care givers have complete knowledge about immunization schedule and benefits ▶ Migrants parents aware of immunization time, place and date

<ul style="list-style-type: none"> ▶ Primary care givers do not take children with illness to the health facility ▶ Limited knowledge of media on AEFI reporting 	<ul style="list-style-type: none"> ▶ Primary care givers take children with illness to the health facility ▶ Media aware of AEFI reporting and know whom to contact for information and what to report.
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* care givers includes fathers, mothers and other family members

5.7. MAJOR TECHNICAL CONTENTS

5.7.1 Routine Immunization

Key Behaviour: Mothers and caregivers will ensure that their children are completely immunized.

- ▶ Immunization protects your children from diseases like tuberculosis, diphtheria, whooping cough, tetanus, polio, measles, Hepatitis B, Homophiles influenza, Rubella, J.E. Ensure that your infant completes the basic series of immunization as per schedule
- ▶ It is responsibility as a parent or caregivers and community to know when and where to take the child for immunization
- ▶ Keep the vaccination card safely and always take the card along with your child during vaccination
- ▶ To get good protection against many diseases, your child need to be fully vaccinated
- ▶ All women of childbearing age should receive TT vaccinations to protect themselves and their babies
- ▶ It is normal for some injections to cause mild side effects such as light fever, soreness and redness. Consult your health worker for advice about what to do if this happens
- ▶ Consult with the FCHV, CHW or health worker to know the benefits of immunization and the schedule in the community.

5.7.2 Supplementary Immunization Activities (Campaign)

Key Behaviour: Mothers and caregivers will ensure that their children receive Supplementary immunization during campaign

- ▶ Take your under five children to a nearby immunization site for polio/measles/JE vaccination on (inclusive date) to the nearby vaccination site

- ▶ Doses given during NIDs/Measles campaign are additional doses to better protect your child
- ▶ Polio kills or cripples children- Vaccinate and protect your child
- ▶ Polio vaccine is safe, free and given as drops in the mouth
- ▶ Encourage your relatives, friends and neighbours to take their children under age five to get polio drops or under 15 child for measles vaccination
- ▶ Every child under five should receive drops during each NID and every child under 15 should receive measles vaccine during measles campaign.

5.7.3 Acute Flaccid Paralysis (AFP) surveillance

Key Behaviour: Mothers and caregivers will seek care if their child shows any signs vaccine preventable disease (VPD)

- ▶ Immediately take any child under age 15 to the nearest health facility if he or she suddenly loses strength in one or both legs or arms
- ▶ Any baby who suddenly stops crawling, standing or sitting to the nearest health facility.

5.8. COMMUNICATION STRATEGY

As EPI programme is implemented through routine and supplementary immunization schedule, communication strategy will take into consideration both modalities. However, the strategic design followed for behaviour change communication programme will be through mutually reinforcing three approaches: advocacy communication, social mobilization communication and behaviour change communication linked with service availability

5.8.1. Advocacy

Advocacy communication strategy is used to gain support for immunisation and to get political and social commitment as well as for resources for the implementation of the programme.

- a. Solicit adequate resources for EPI programme communication, support to monitor the progress at various level and provision of vaccinators at communities. Stimulate private and public health institutions: (IOM, CTEVT etc.) to integrate immunization issues in pre and in service. ANM, HA, SN curricula
- b. Include working group members who have expertise in communication and service delivery

- c. Formulate or strengthen inter agency coordinating committee for better coordination and programming on immunization
- d. Strengthen surveillance system to deal with outbreaks and other disease emergencies
- e. Garner support from media and civil society organizations in case of AEFI.

5.8.2 Social Mobilisation

Social mobilization communication is important for ensuring the involvement of people at all levels to obtain support for immunisation. Social mobilization activities will be conducted to mobilize resources at the district and community level.

- a. Conduct/continue district and community level micro planning to identify hard to reach communities
- b. Promote use of participatory learning and decision-making methods to improve community involvement and ownership of EPI programme
- c. Mobilize different community group.

5.8.3 Behaviour Change Communication (BCC)

BCC strategy will inform people and solicit their desired behaviours about immunization services and its benefits and will encourage mothers and families to bring their children for routine immunization as well as during the campaigns.

- a. Carry out audience and service utilization research to better plan immunization programme and campaigns
- b. Development and dissemination appropriate communication channels and materials to reach key participant groups. Use of suitable avenues to integrate immunization messages. For example: Birth preparedness package, CB-NCP, CB-IMCI, Schools
- c. Mobilization of existing networks to address resistance for immunization.

5.9. COMMUNICATION ACTIVITIES

5.9.1 Advocacy

- a. **Formative research.** Review existing behaviour data, barriers to access services, communication gaps, needs, media preferences and availability of materials at the national and district levels through desk review and field research. Carry out research/ investigate why the populations are hard to reach and their behaviour

- b. Advocacy toolkits.** Develop advocacy toolkits for donors, policy makers and parliamentarians including recent facts and figures
- c. High-visibility programme.** Organize high visibility programmes such as media events, advocacy meetings, symposia, conferences and campaigns from time to time to motivate partners, capture national interest and create peaks in programme implementation
- d. Publicize programme.** Publicize programme successes and challenges widely in the media. Send time to time updates of programme achievements (routine and campaigns) and challenges to key policy makers, ministries and development partners
- e. National Campaigns.** Launch NIDs or campaigns by celebrities or key influential leaders, goodwill ambassadors and announcements through mass media and megaphones. Disseminate NID, campaign and routine immunization messages at rallies, worships, processions, public meetings. Use megaphones to disseminate NIDs and campaign messages in various public gatherings
- f. Media:** Conduct sensitization meeting with media and journalists to garner support for routine immunization programme, campaigns and in case of AEFI.

5.9.2 Social Mobilization

- a. Develop/strengthen structures at district and VDC level implement immunization focusing to reach out to hard to reach groups.** Strengthen or develop structures that support communication in the community (village development committees, health management committees). School management committee, local NGO, Clubs etc. Develop specific plans at the district level to reach out to hard to reach groups
- b. Organize group communication meetings.** Provide orientation training to key leaders to generate support and commitment for the immunization coverage and programme and invest resources in immunization programmes
- c. Prepare toolkits and assists in training.** Develop toolkits and train volunteers and health workers (vaccinators) to equip them with IPC skills and their roles
- d. Organize community events.** Organize immunization day mass rallies, talk programmes, to communicate the importance of public support for immunization activities on mass scale and create public sentiment on organized efforts for immunization programme. Organize public hearings to encourage ownership and raise commitment for the immunization activities. Incorporate local group

- e. **National Campaigns.** Launch NIDs or campaigns by celebrities or key influential leaders, goodwill ambassadors and announcements through mass media and megaphones. Disseminate NID, campaign and routine immunization messages at rallies, worships, processions, public meetings. Use megaphones to disseminate NIDs and campaign messages in various public gatherings.

3.9.3 Behaviour Change Communication (BCC)

- a. **Educational Materials.** Develop/adapt/revise behaviour change communication materials on immunization for key participant groups and health workers to enhance counselling and communication skills
- b. **Local Events.** Launch NIDs or campaigns by celebrities or key influential leaders, goodwill ambassadors and announcements through mass media and megaphones. Disseminate NID, campaign and routine immunization messages at rallies, worships, processions, public meetings. Use megaphones to disseminate NIDs and campaign messages in various public gatherings
- c. **Disseminate messages** using logos, leaders' statements, posters, newspapers, radio and TV programmes, public service announcements, press conferences, newspaper editorials, street dramas, calendars, banners, billboards etc
- d. **Community level Promotion.** Use large networks of health workers, volunteer and other existing networks to reach individual households especially hard to reach families
- e. **Reach out to Urban Populations.** Make specific urban strategies to reach out to migrant families who may not be aware of immunization schedules, location and days.

5.10. MONITORING AND EVALUATION

For assessment of effect of communication related to immunization, data will be collected during the coverage survey at the same time of immunization campaign. DHS will also collect some data on communication and this will be continued in future. NHEICC surveys will also specifically include questions on communication on immunization. Monitoring will also be done through regular HMIS data. Based on the data trend, strategies for communication will be modified and revised as necessary.

Lessons learnt from specific immunization communication projects and events will be shared at the national level to discuss what has worked and what needs improvement. Based on the learning, efforts will be made to strengthen communication activities and formulation of additional strategies for immunization.

Monitoring through Independent groups e.g. social auditing, professional bodies, community groups will be carried out. Community level monitoring will focus on effects of dissemination of message

5.10.1 Indicators for Advocacy

- ▶ Proportion of resources allocated for IEC/BCC under immunization is ensured.

5.10.2 Indicators for Social Mobilization

- ▶ Percentage of district plans that identify and give strategies to address reaching hard to reach and resistant from certain groups
- ▶ Number of awareness raising events held at district and community

5.10.3 Indicators for Behaviour Change Communication

- ▶ Percentage of mothers/caregivers of under one child who know when the next immunization is due
- ▶ Percentage of mothers/caregivers of under one child who know where and when to take their child for complete immunization
- ▶ Percentage of mothers/caregivers who know that NIDs do not replace routine immunization
- ▶ Percentage of children who are fully immunized
- ▶ Percentage of children receiving polio during each NIDs
- ▶ Percentage of children receiving measles vaccine during measles campaign
- ▶ Percentage of children receiving vaccination during campaign.

6.1. BACKGROUND

Under nutrition remains a serious obstacle to child survival, growth and development in Nepal. The most common form of under nutrition is protein-energy malnutrition (PEM). The other forms of malnutrition are iodine, iron and vitamin A deficiency. Each type of malnutrition wreaks its own particular havoc on the human body, and to make matters worse, they often appear in combination. Malnutrition is associated with one third of child mortality in Nepal. One of the important causes of PEM in Nepal is low birth weight (LBW) of below 2.5 kg, a sign of poor maternal nutrition leading to an intergenerational cycle of malnutrition.

- ▶ In 2006, almost half of under 5 children were stunted, 39% were underweight and 13% were wasted. These numbers have improved recently, but are still high: 41% are stunted, 29% are underweight and 11% are wasted, according to the preliminary findings from the 2011 NDHS. Stunting is higher in mid and far western mountain region. Wasting is higher in eastern and central Terai region. Anemia is highest in the Terai (50.2%), followed by the Mountain (47.7%) and Hill (41%) regions
- ▶ Nearly one in every two (46.2%) children aged under five are anaemic²
- ▶ 34% of babies have low birth-weight. The prevalence of LBW babies in Nepal was reported as between 20-32% in hospital-based studies and 14-19% in community-based studies. In 2011, 29% of children were found to be underweight, and 8% severely underweight
- ▶ Proper breastfeeding and complementary feeding practices are insufficient. Only 70% of children are exclusively breastfed for the first six months. Also, 1 in 3 women (35%) initiates breastfeeding within one hour of delivery
- ▶ Complementary feeding practice is 68%. Only 3 out of 5 children (57%) are fed according to recommended practices
- ▶ 36% of reproductive age women (15-49) and 42% pregnant women are anaemic, but iron compliance is still low. Anaemia is higher in mid and far terai region.

² DHS (2006) and DHS (2011, preliminary findings). Nepal Demographic and Health Survey. Ministry of Health and Population, Government of Nepal, Kathmandu, Nepal.

Furthermore, a widening of the gap in nutritional status across wealth quintiles is also observed with children from lowest wealth quintile facing the highest burden of malnutrition. This problem is exacerbated in rural and mountainous regions. Effective delivery of nutrition interventions from pregnancy to 24 months of child age (1000 days) is the critical window of opportunity.

6.2. PROGRAMME GOAL AND OBJECTIVES

Improving nutritional status of children and women has been recognised as the top priority by the Government in line with the MDGs, World Fit for Children's (WFC) Goals and the NHSP IP-II. Major interventions will be improving feeding practices, child growth monitoring with effective counselling, micronutrient supplementation, and fortified blended ready-to-use food. However, as malnutrition is also related to deeper problems of poverty and food insecurity, it requires a response that is wider than the health sector.

Malnutrition is caused by inadequate food intake (in quantity and quality and frequency), and ailments that sap the body's ability to retain nutrients. Therefore the strategy also promotes disease prevention through sanitation and hand washing. To address inadequate food intake, the programme focuses on maternal and infant and young child feeding, micronutrient supplementation, promotion of locally available food and proper gardening and farming strategies.

Action against protein-energy malnutrition focuses on protection, promotion and support for optimal feeding practice for infants and young children by building capacity on infant and young child feeding (IYCF) counselling, increasing the coverage of growth monitoring at health facilities, linked with BCC for changing dietary practices and raising awareness on appropriate feeding practices. Other strategies are the strengthening of nutrition rehabilitation homes, community management of acute malnutrition (CMAM) and improving maternal nutrition to reduce low birth weight.

The desired national objectives of the programme are:

- ▶ To protect, promote and support optimal feeding practice for women, infants and young children
- ▶ To reduce PEM in children under 5 and women of reproductive age (including adolescents)
- ▶ To reduce the prevalence of anemia among women of reproductive age and children
- ▶ Eliminate IDD and Vitamin A Deficiency and sustain the elimination
- ▶ To reduce infestations of intestinal worm among pregnant and breastfeeding women and children
- ▶ To reduce prevalence low birth weight babies

6.3. COMMUNICATION GOAL

Women and caregivers will have knowledge, skills and motivation for improved home-based healthy dietary and feeding practices, early recognition of nutrition related consequences and the importance and timing of seeking nutrition services such as deworming, iodized salt, vitamin A and iron supplementation.

6.4. COMMUNICATION OBJECTIVES

Mothers and Families

- ▶ Increase practices of exclusive breastfeeding of the child's up to first 6 months
- ▶ Increase self-efficacy to breastfeed exclusively up to first 6 months
- ▶ Increase knowledge on the benefits of early, exclusive and extended breastfeeding
- ▶ Increase knowledge of improved hand washing and sanitation practices
- ▶ Increase acceptance and encouragement of wives' exclusive breastfeeding during the child's first 6 months
- ▶ Improve complementary feeding practices based on IYCF national guidelines
- ▶ Increase awareness on the need for continuing to feed regular food and breast milk during child's illness and increased self-efficacy to do so
- ▶ Increase ability to recognize malnutrition and knowledge about referral sites
- ▶ Increase knowledge about and use of Vitamin A, deworming tablets, iodized salt, iron, and folic acid
- ▶ Increase knowledge of importance of ensuring adequate nutrition intake of adolescent girls
- ▶ Increase knowledge of nutritious locally available foods
- ▶ Increase discussion about correct nutrition practices among friends and family.

Health Providers

- ▶ Increase recommendations by providers to mothers for exclusive breastfeeding of their child's up to first 6 months
- ▶ Increase monitoring of regular growth of all children under 5
- ▶ Increase recommendations by providers to mothers for use of Vitamin A, deworming tablets, micro nutrients, iodized salt, iron and folic acid and improved nutrition practices.

6.5. AUDIENCE

Strategic Communication Approachs	Audience Category
Advocacy Communication	Policy Makers: MOHP, CHD, NHEICC, NHTC, FHD, LMD Ministry of Agriculture and Livestock, Ministry of Education, Ministry of Local Development, Federation of Nepalese Chamber of Commerce and Industries, Nepal Chamber of Commerce and Industries, Ministry of Industries and Commerce, Political leaders, Media, Health Facility Management Committee, Salt Trading Cooperation, EDPs, Women and Children Officers, Ministry of Finance
Social Mobilization Communication	NGO/CBOs, women groups/health mother groups, saving and credit groups, Community forest user groups, school teachers, Red Cross, child and youth clubs, civil society and health workers, JTA, FCHVs, community volunteers, faith healers, religious leaders, ECD facilitators, Food Suppliers, farmers associations, Pharmacist/drug vendors, Students
Behaviour Change Communication	Primary: Mothers, Pregnant Women, Adolescent, Secondary: Mother in laws, Fathers, other care givers, Other family members, School children Health care providers

6.6. OVERVIEW OF EXISTING AND DESIRED BEHAVIOURS

The Nutrition communication strategy is based on the behaviour analysis, below.

Figure 4.1
Existing and desired behaviour regarding Nutrition

6.6.1. Existing behaviours	6.6.2. Desired behaviour change
▶ Mothers do not initiate BF within one hour of birth and colostrum discarded	▶ Mothers initiate BF with colostrum milk within one hour of birth

<ul style="list-style-type: none"> ▶ Babies given plain water along with breast milk ▶ Children given prelacteal feeds (honey, ghee, goat milk) ▶ Mothers not confident about her ability to breastfeed ▶ Children are not given correct complementary feeding after completing 6 months ▶ Strong existence of taboos on what to eat and what not to eat during illness and child birth ▶ Growth Monitoring drops after completion of immunization as families unaware about the importance of assessing the nutritional status of children through GM ▶ Children are not provided regular food during illness ▶ Families are not able to recognise signs and symptoms of under nutrition on time ▶ Health workers have limited skill and knowledge on nutrition counselling ▶ Only 25% pregnant women and lactating mothers are completing 180+45 days of iron supplementation ▶ Pregnant women and lactating mothers are not receiving proper (frequency, quality and quantity) of food 	<ul style="list-style-type: none"> ▶ Stop giving water to infant aged up to 0-6 months unless medically advised ▶ Children are exclusively breast fed up to six months ▶ Mothers are confident that they can breastfeed their children ▶ Appropriate complimentary feeding introduced at 6 months of age ▶ Increased knowledge on importance of consuming age specific (frequency, quality & quantity) locally available nutritious food ▶ Timely and regular growth monitoring visit as per recommended schedule ▶ Increased knowledge on the need of continuing to feed regular food during illness ▶ Increased knowledge on how to recognize under nutrition and where to refer ▶ Improved skill and knowledge regarding GM and nutrition counselling among health workers ▶ Pregnant women and lactating mothers receiving iron tablets after 1st trimester of pregnancy comply with the full course of 180+45 days ▶ Pregnant and lactating mothers receive adequate locally available variety of mixed food
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<ul style="list-style-type: none"> ▶ 20% Nepali women consume tobacco, while 50% of them continue its use during pregnancy ▶ 64% children from 6-35 months consume vitamin 'A' rich foods ▶ 29% women receive vitamin 'A' during postpartum ▶ Only 36% of pregnant women take de-worming tablets ▶ Inadequate practice of proper hand washing among the children and women ▶ 80% household using adequately iodized salt 	<ul style="list-style-type: none"> ▶ Cessation of tobacco use ▶ Women and caregivers provide locally available Vitamin A rich food to 6-35 months children ▶ All postpartum women receive Vitamin 'A' supplementation within 6 weeks of delivery ▶ Pregnant women consume single dose de-worming tablet from 2nd trimester ▶ Children and women wash their hands properly with soap and water during six critical times (see below) ▶ All households use adequately iodized salt (2 child logo packet salt)
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6.7. MAJOR TECHNICAL CONTENT

6.7.1 Hygiene and Sanitation

Key Behaviour: Hand washing during the six critical times.

- ▶ Mothers and caregivers wash hands with soap and water before preparing and eating food, before feeding baby, after using the toilets and touching soil during six critical times: 1) after defecation, 2) before preparing meals or before feeding children, 3) after cleaning a child's bottom, 4) before eating, 5) before and after attending sick person and 6) before touching newborn
- ▶ Always drink safe (boil or filter or chlorinated, sodis) water. Maintaining safe water storage to prevent contamination.
- ▶ Maintain a safe, clean and hygienic environment to prevent parasitic infestation and disease infections.
 - ◆ Latrine construction and use
 - ◆ Proper disposal of faeces
 - ◆ An established hand washing station with water and soap
 - ◆ Animal management (in cages or pens) for cleaner environment

6.7.2 Age wise Technical Content for Communication

Age	Key Desired behaviour with content
<p>Newborns to up to 6 months</p>	<p>Key Behaviour: Early and exclusive breastfeeding for first six months</p> <ul style="list-style-type: none"> ▶ Begin breastfeeding within 1 hour of birth ▶ Colostrum, the first thick yellowish milk is good for your baby. It protects babies against most infections ▶ Exclusive breastfeeding means feeding your baby only breast milk up to six months and nothing else (no other milks, food or liquids, not even water) ▶ Breast milk contains all the food and water that your baby needs during the first 6 months of life, so, do not give water for up to first 6 months unless medically advised ▶ Exclusive breastfeeding up to the first 6 months protects your baby from many illness, such as diarrhoea and respiratory illness ▶ Breastfeed baby on demand day and night, 10 or more times in 24 hours ▶ Besides good nutritional and health status of mother and good positioning and attachment during breastfeeding helps to produce a good supply of breast milk ▶ Breastfeeding helps to bring uterus in its normal size and increases beauty of mother ▶ If a child becomes sick, important to continue feeding the child normally ▶ Sharing of mother's workload to provide her for sparing sufficient time for breastfeeding and take care of her child <p>Key Behaviour: Regular Growth Monitoring</p> <ul style="list-style-type: none"> ▶ Take your baby to nearest health facilities or outreach clinics for monthly growth monitoring to make sure your baby is growing well.

<p>6 Months to up to 2 years</p>	<p>Key Behaviour: Continued breastfeeding up to 2 years with complementary food based on guidelines</p> <ul style="list-style-type: none"> ▶ Baby should be started with thick semi solid food after 6 months along with breast milk, and other milk till the age of 2 years ▶ 3 times semi solid thick foods like (poshilo Jaulo, Poshilo litto, mashed rice mixed with green leafy vegetables mainly karkalo, Sisnu and Coriander leaves, legumes and lentils soup) cereals, pulses, legumes, fat & oil (ghee), milk & milk product, meat, fish & poultry products ▶ 1 time daily locally available seasonal fruits ▶ Babies have small stomach, and cannot eat a larger portion at a time, and cannot swallow solid foods. They require foods frequently with adequate consistency, thickness and soft texture ▶ After child is one year, mothers can give 1 time one extra small portion of regular family meal or "snack" ▶ Always use 2 child logo packet salt ▶ Ensure child receives semi-annual vitamin 'A' supplementation and deworming through FCHVs <p>Key Behaviour: Growth Monitoring</p> <ul style="list-style-type: none"> ▶ Take your baby to nearest health facilities or outreach clinics for monthly growth monitoring to make sure your baby is growing well.
<p>2-5 years</p>	<p>Key Behaviour: Children age 2-5 are fed based on nutrition guidelines as follows:</p> <ul style="list-style-type: none"> ▶ At least two tea glasses of milk per day ▶ 3 times daily (combining variety of foods) <ul style="list-style-type: none"> ◆ Animal Source foods: meat, egg, and dairy products ◆ Staples (grains, roots and tubers) ◆ Legumes and Seeds ◆ Vitamin A and iron rich locally available green and other vegetables

	<ul style="list-style-type: none"> ◆ Two child logo packet salt ▶ 1 time daily locally available seasonal fruits ▶ 1 time daily small meal/snacks ▶ Ensure child receives semi-annual vitamin 'A' supplementation and deworming through FCHVs <p>Key Behaviour: Growth Monitoring</p> <ul style="list-style-type: none"> ▶ Take your baby to nearest health facilities or outreach clinics for monthly growth monitoring to make sure your baby is growing well.
<p>Pregnant and Breastfeeding Women</p>	<p>Key Behaviour: Pregnant and breastfeeding women are given adequate support and nutrition for healthy pregnancy and breastfeeding</p> <ul style="list-style-type: none"> ◆ 4 times meal (combining variety of foods but larger quantity) ◆ Staples (mixed of grains, roots and tubers) ◆ Legumes, lentils, Seeds ◆ Vitamin A and Iron rich locally available green and other vegetables ◆ Animal Source foods: meat, egg, and dairy products ◆ Two child Logo packet salt ◆ 1 extra snack ◆ Tomato, citric food, lemon and sprouts. ◆ Avoid tea/coffee and smoking <ul style="list-style-type: none"> ▶ Pregnant and breastfeeding mothers should take iron and folic acid from the fourth month of pregnancy to 45 days after delivery ▶ Pregnant women should receive deworming medicine from the health facility during the 1st trimester of pregnancy ▶ Every mother after delivery should get Vitamin A within 6 weeks of delivery.

10-19 Adolescent Girls	<p>Key Behaviour: Adolescent girls age 10-19 are given adequate support and nutrition</p> <ul style="list-style-type: none"> ▶ At least two tea glasses of milk ▶ 3 times food during regular family meal (combining variety of foods but larger quantity) <ul style="list-style-type: none"> ◆ Animal Source foods: meat, egg, and dairy products ◆ Staples (grains, roots and tubers) ◆ Legumes and Seeds ◆ Vitamin A other minerals rich locally available green and other vegetables ◆ Two child logo packet salt ▶ 1 time locally available seasonal fruits ▶ 1 extra snack ▶ De-worming tablets (semi-annual) ▶ Weekly Iron tablets for 13 weeks.
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6.8. COMMUNICATION STRATEGY

The communication strategies for interventions on nutrition are focused on three mutually supporting communication approaches namely advocacy communication, social mobilization communication and behavioural change communication. The specific strategies under each of the approaches are given below :

6.8.1 Advocacy

Advocacy communication will be carried out among policy and decision-makers, programme managers and sectoral line agencies :

- ▶ Establish coordination mechanism with all relevant existing partners (Ministry of Finance, Ministry of Agriculture and Cooperatives, Ministry of Education, Ministry of Local Development and Ministry of Industries and Commerce, FNCCI, NCCI) and communication specialists for evidence-based program design and effective implementation of nutrition interventions and develop strategic partnership to promote nutrition issues at all levels
- ▶ Strengthen partnerships with private sectors and government cooperation to increase and improve food availability, sustainability, accessibility and affordability especially during critical food storage periods

- ▶ Solicit adequate resources and partnership for nutrition programme communication and support to implement and monitor the programmes at various levels
- ▶ Develop/revise appropriate policies and guidelines on breastfeeding, complementary feeding, de-worming, and consumption of Vitamin A, iron, and other micronutrients
- ▶ Integrate key nutrition messages into essential health packages
- ▶ Strengthen monitoring of nutrition programme communication activities.

6.8.2 Social Mobilization

Social mobilization communication among various organizations and groups will be carried out:

- ▶ Formation/Activation of district level nutrition steering committee to coordinate and plan nutrition promotion activities at district and VDC level
- ▶ Mobilize district level stakeholders and their resources to prioritize initiatives to leverage support and awareness for nutrition
- ▶ Mobilize pool of existing interpersonal communication networks of health, agriculture, saving and credit and forestry groups for promoting dietary requirement, locally available foods and distribution of nutrition supplements through national and community level mechanisms (civil society, women's groups, etc).

6.8.3 Behaviour Change Communication (BCC)

Behaviour change communication will be followed using IPC and mass media to promote colostrums and exclusive breast feeding practices and creating supportive environment to adopt the behaviour.

- ▶ Produce/Compile information on current knowledge, attitudes and practices of families, communities on breastfeeding, complementary feeding, de-worming, Vitamin A and iron supplementation, use of iodised salt, variety of food items consumption, malnutrition signs and symptoms and service seeking behaviour
- ▶ Develop clear, simple, easy to understand key messages and materials on nutrition (breast feeding, complementary feeding, supplements, food requirements (quantity, quality), household hygiene and sanitation practices focusing communities especially hard to reach and most at risk populations
- ▶ Develop standard contents and messages to be used by all the stakeholders of nutrition

- ▶ Use of available mass media, local media and interpersonal communication through existing channels to promote nutrition for children, adolescent girls, pregnant women and lactating mothers
- ▶ Strengthen utilization of message delivery channels to reach hard to reach and most at risk populations
- ▶ Build capacity of health service providers and volunteers to promote nutrition issues including hygiene and sanitation at families and community levels.

6.9. COMMUNICATION ACTIVITIES

6.9.1 Advocacy

- a. **Nutrition Committee.** Hold regular coordination meetings of key strategic partners in nutrition for joint planning, technical updates and to ensure media and materials sharing and regular lessons learned
- b. **Develop advocacy tool kits** for policy makers, parliamentarians and ministries to demonstrate the importance of nutrition programmes for contributing to the MDGs and make a case for increased investments and coordinated efforts. Monitor, promote, and coordinate the use of advocacy tools across organizations working in the nutrition and maternal/child health sectors
- c. **Policy.** Review, revise and reactivate breastfeeding act to include a leave provision for working mothers till 6 months after delivery and provision of breast feeding space at workplace
- d. **Engage the media.** Train media persons to stimulate use of media outlets, raise awareness and report of critical issues related to nutrition programme.

6.9.2 Social Mobilization

- a. **Form district and VDC food committees** Create local forums for health and agriculturalists to promote entrepreneurship for distribution and marketing of locally available nutritious food
- b. **Build networks of champions** and advocates among key influencers of change at community level. Train and mobilize large networks of FCHVs, agriculture workers, teachers, religious leaders and other volunteers as nutrition communicators at community level.

6.9.3 Behaviour Change Communication

- a. Motivate religious leaders. Train and mobilize religious leaders for promotion of locally available nutritious foods for health and well being of children, adolescent girls and women

- b. Analyse/compile existing studies on community knowledge, attitudes and practices and share with relevant stakeholders. Conduct new studies as needed
- c. Develop clear, simple and culturally appropriate messages and pictorial materials for mothers and caregivers
- d. Disseminate localized messages using mass media, traditional media and interpersonal channels
- i. Organize Fun and Food fair events. (Focus display of locally available foods) at VDC and district level targeting children and adolescents. This may include kitchen gardening, making seeds available, agricultural or cooking techniques, marketing, etc
- ii. Conduct school-based activities Such as school garden clubs, contests, theatre, etc. and ECD center outreach
- iii. Use new electronic technologies and other social media (face book, SMS, twitter) to discuss nutrition message with mothers/ caregivers and adolescents
- iv. Promote 2-child logo for iodized salt using social marketing techniques through various channels
- v. Design messages which reach mobile populations including the urban poor.

6.10. MONITORING AND EVALUATION

Monitoring and evaluation will be done on regular basis. The following process and behaviour indicators can be used to monitor and evaluate the effects of communication on nutrition communication

Indicators for Advocacy

- ▶ Breast feeding policy development and endorsed by policymakers
- ▶ Advocacy tool kit developed and disseminated to various stakeholders
- ▶ Number of coordination sessions held with stakeholders in order to promote advocacy strategies
- ▶ Number of policymakers briefed on research findings pertaining to breastfeeding & nutrition
- ▶ Number of hearings held at the village, district, and national levels pertaining to breastfeeding and nutrition
- ▶ Number of nutrition champions.

Indicators for Social Mobilization

- ▶ Number of events organized to promote nutrition at district level
- ▶ Number of events organized to promote nutrition at the village level
- ▶ Number of NGOs/CBOs engaged in campaigning on use of iodized salt and iodine rich foods
- ▶ Number of community organizations (including youth and women's groups) reached with breastfeeding and nutrition messages.

Indicators for Behaviour Change Communication

Key Behaviour: Handwashing at the six critical times

- ▶ Percentage of families able to state six critical times for hand washing (1) after defecation, 2) before preparing meals or before feeding children, 3) after cleaning a child's bottom, 4) before eating, 5) before and after attending sick person and 6) before touching newborn)
- ▶ Percentage of families demonstrating that they are washing their hands at six critical stages.

Key Behaviour: Breastfeeding exclusively up to 6 months

- ▶ Percentage of mothers and fathers aware of benefits of early and exclusive breastfeeding to 6 months of age
- ▶ Percentage of mothers who feel efficacious in their ability to breastfeed exclusively up to 6 months
- ▶ Percentage of fathers who encourage their wives to breastfeed exclusively up to 6 months
- ▶ Percentage of health providers encouraging mothers to breastfeed exclusively up to six months
- ▶ Percentage of children exclusively breastfed up to six month of age.

Key Behaviour: Growth Monitoring

- ▶ Percentage of Mothers and care givers aware of the benefits of growth monitoring
- ▶ Percentage of mothers and care givers regularly visiting health facilities for growth monitoring
- ▶ Percentage health workers encouraging mothers and caretakers to have regular growth monitoring

Key Behaviour: Improved supplemental feeding practices

- ▶ Percentage of mothers and care givers aware of correct complementary feeding from the age of 6 months to at least up to 2 year of age
- ▶ Percentage of mothers and care givers providing complementary feeding as per national IYCF guidelines.

Key Behaviour: Improved nutrition for pregnant and breastfeeding women

- ▶ Percentage of pregnant women and breastfeeding mothers aware of the importance of and timing of iron supplementation and Vitamin A
- ▶ Percentage of women who take dose of Iron supplement and Vitamin A after delivery
- ▶ Percentage of adolescent girls, pregnant women and breastfeeding mothers aware of the importance and ways of appropriate IHFD
- ▶ Percentage of adolescent girls, pregnant women, breastfeeding mothers, and children receiving equitable foods in the family
- ▶ Percentage households using two child logo pack salt
- ▶ Percentage of households with knowledge about locally available nutritious food.

7.1. COORDINATION

As per the guidelines regarding health education and communication outlined in the NHSP II, the NHEICC is charged with multi-sectoral coordination and collaboration, including all divisions and centres of the MoHP and with other development partners, nongovernmental organizations (NGOs), and international nongovernmental organizations (INGOs) for health communication. Here the coordination with the Child Health Division and Family Health Division including other related organizations is paramount. In addition, the coordination with the maternal and child health-specific programs of other line ministries (education; youth and sports; women, children and social welfare, local development etc.) is required. Necessary coordination will be made to SMNCH and Adolescent Sexual and Reproductive Health Sub-committee of FHD and child health related sub-committees of CHD. Relevant coordination structures to address these needs are already in place and can be continued to implement this strategy. These include:

National Level:

- ▶ National IEC/BCC Coordination Committee
- ▶ National IEC/BCC Reproductive Health Technical Committee
- ▶ National IEC/BCC Child Health Technical Committee.

District Level:

- ▶ Reproductive Health Coordination Committee (RHCC).
- ▶ Detail terms of references of above committees are attached in annexe II.

7.2. MANAGEMENT STRUCTURE

At national level, a national MNCH communication strategy implementation plan should be developed subsequent to the endorsement of this strategy including a clearer definition of the prioritized key behaviour development and behaviour change of related audiences. Other strategic documents such as the National Communication Strategy on Family Planning and Adolescent Reproductive Health (2012–2016) should also be considered. Nepal Demographic and Health Survey 2011 data will be further considered during the development of the communication implementation plan. The programming process should also take into account the division of labour

between the central level and the regional and district level and below level. It should clearly lined out responsibilities and timelines in order to operationalize the strategy.

Implementing this strategy in the field will require strong support from NHEICC and its governmental, non-governmental and external development partners. The existing health system coordination functions will be used at national and decentralized level of health system. As this communication strategy provides support to the National MNCH program of FHD and CHD, which is managed by DHO/DPHOs at the district level, SHP/HP/PHCs at the village level and FCHVs at community/ward level, the communication activities need to be implemented in cooperation with these health system and volunteers in the decentralized health system. DHO/DPHO will roll this strategy out to districts in the context of regular district planning meetings for its smooth implementation. In particular, health education officer at regional level under the leadership of regional health director and health education technician or health education focal person at district level under the leadership of DHO/DPHO will be the key to implement this strategy. The abolition of the District Health Education Technician (HET) post can be major bottleneck for implementing this strategy smoothly. Therefore, the abolished position of health education technicians will be revived as permanent personnel are still working as it is in their respective district public health offices.

Non-governmental actors and external development partners will align their projects on maternal and child health promotion and communication with this strategy. They should use this strategy as a framework for their current and future projects and interventions on maternal and child health promotion and communication. Similarly, they will coordinate with NHEICC through the relevant coordinating mechanisms and technical committees of this strategy for aligning current and future projects and interventions on maternal and child health promotion and communication .

7.3. NEXT STEPS

Next steps after strategy endorsement will be to develop a detailed implementation plan for the different components of the strategies. The implementation plan will outline specific strategies, objectives, audiences, messages, channel, timeline, responsibilities, resources, outputs and means of verifications. Similarly, national, regional, district and below level strategies and its components will be defined in the implementation plan based on the endorsed national strategy. The organizations responsible for the implementation will then formulate their own action plans, including conducting any necessary formative research, if necessary.

LIST OF PARTICIPANTS OF STRATEGY DEVELOPMENT WORKSHOP

ANNEX
1

Mr. Laxmi Narayan Deo	Director	NHEICC
Mr. Badri Bahadur Khadka	Chief, Health Education & Promotion Section	NHEICC
Mr. Raj Kumar Pokharel	Chief, Nutrition Section	CHD
Mr. Krishna Bahadur Chand	Chief, EPI Section	CHD
Mr. Parashu Ram Shrestha	Chief, IMCI Section	CHD
Dr. Shilu Aryal	Chief, SM Section	FHD
Ms. Sanju Bhattarai	Program Officer	UNICEF
Ms. Chahana Singh	Program Officer	UNICEF
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Dr. Ashish KC	Program Coordinator	Save the Children
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Mr. Babau Ram Acharya	Program Officer	NFHP
Mr. Khem Raj Shrestha	BCC Coordinator	NFHP

LIST OF PARTICIPANTS AND GUESTS OF STRATEGY DEVELOPMENT WORKSHOP

Dr. Yashovardhan Pradhan	Director General	DoHS
Dr. Kiran Regmi	Director	FHD
Mr. Laxmi Narayan Deo	Director	NHEICC
Mr. Raj Kumar Pokharel	Chief, Nutrition Section	CHD
Mr. Krishna Bahadur Chand	Chief, EPI Section	CHD
Mr. Parashu Ram Shrestha	Chief, IMCI Section	CHD
Dr. Shilu Aryal	Chief, SM Section	FHD
Mr. Badri Bahadur Khadka	Chief, Health Education & Promotion Section	NHEICC
Ms. Sanju Bhattarai	Program Officer	UNICEF
Ms. Chahana Singh	Program Officer	UNICEF
Mr. Nabin Paudel	Program Officer	UNICEF
Dr. Ashish KC	Program Coordinator	Save the Children
Ms. Srijana Sharma	Communication Officer	Save the Children
Mr. Pradiumna Dahal	Program Officer	Save the Children
Mr. Babau Ram Acharya	Program Officer	NFHP
Mr. Khem Raj Shrestha	BCC Coordinator	NFHP

CONTRIBUTORS IN STRATEGY FINALIZATION SMALL GROUP MEETING

Mr. Badri Bahadur Khadka	Director	NHEICC
Mr. Rajkumar Pokharel	Chief, Nutrition Section	CHD
Mr. Krishna Bahadur Chand	Chief, EPI Section	CHD
Mr. Parasu Ram Shrestha	Chief, IMCI Section	CHD
Dr. Shilu Aryal	Chief, SM Section	FHD
Mr. Lakshmi Narayan Deo	Chief, Tobacco Control Section	NHEICC
Mr. Kunj Joshi	Senior HEO	NHEICC
Mr. Baburam Acharya	Program Officer	NFHP
Mr. Dilip Chandra Paudel	DL, Child Health Section	NFHP
Mr. Khem Raj Shrestha	BCC Coordinator	NFHP
Ms. Deepa Risal Pokharel	Chief, Comm Section	UNICEF
Ms. Sanju Bhattarai	Program Officer	UNICEF
Dr. Sudhir Khanal	Program Specialist	UNICEF
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Mr. Nabin Paudel	Program Officer	UNICEF
Ms. Shreejana KC	Program Officer	UNICEF
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Dr. Ashish KC	H & N Program Manager	Save the Children
Ms. Neera Sharma	Sr. Program Coordinator	Save the Children
Ms. Nirmala Sharma	Health Program Coordinator	CARE
Ms. Gyanu Shrestha	IEC/BCC Coordinator	NHEICC

COORDINATION AND TECHNICAL COMMITTEES FOR IEC/BCC

A. NATIONAL IEC COORDINATION COMMITTEE

Purpose

The national IEC coordination committee has been established to ensure functional coordination between multi-sectoral stakeholders in the National IEC/BCC programs. The specific objectives and responsibilities of this committee are as follows.

- ▶ Provide policy guidance and technical support to Technical Committees as and when needed
- ▶ Encourage cooperative action in health programs and services in between the stakeholders
- ▶ Coordinate with government, non-government and related stakeholders in IEC/BCC programs
- ▶ Provide consent and feedback the committees on technical aspects as and when needed
- ▶ Make processes to endorse the health related IEC/BCC policy and strategy
- ▶ Direct for addressing and materialization of one door system for IEC/BCC in health.
- ▶ Provide a forum to discuss and address issues that needs government attention (policy and operational level)
- ▶ Raise, discuss, formulate and recommend policy and strategic issues.

Composition

The Director General of Department of Health Services / MOHP will be the chairperson of the National IEC/BCC Coordination Committee. Members will include Directors of the Divisions, Centers and Department of Drug Management, Department of Aurved, chief of the Public Health Administration, Monitoring and Evaluation Division and chief of the Policy, Planning and International Cooperation Division of Ministry of Health and Population. The Director of National Health Education, Information and Communication Center will serve as the member secretary of committee. Media channels, multi-lateral and bilateral external development

partners, NGOs and other stakeholders will be invited as and when necessary in the national IEC/BCC coordination committees. The committee meeting will be held twice in a year.

B. TECHNICAL COMMITTEES FOR IEC/BCC

There will be technical committees under national IEC/BCC coordination committee and meeting will be held as and when necessary. The composition and terms of references of the technical committees are as follows.

Terms of reference of the technical committees:

1. Serve as a technical resource in different issues of maternal and child health content on behalf of GoN/MoHP for government and other stakeholders
2. Provide a forum for sharing and disseminating information, experiences, research findings, best practices and lesson learned
3. Identify key health issues and recommend designing IEC/BCC activities accordingly
4. Enhance commitment to the national health education program through coordination and cooperation with the related stakeholders
5. Facilitate in the idea generation, message and materials design and media use and implementation
6. Coordinate service and program divisions during approving technical content for messages and materials on MNCH
7. Approve technical content for messages and materials of IEC/BCC on MNCH and provide consent to the stakeholders for producing and disseminating uniform, appropriate and consistent health messages and materials as per policy and strategy of MoHP
8. Provide a forum to discuss and address issues that needs government attention (policy, programs and activities at all level)
9. Identify research needs in the area of IEC/BCC
10. Raise, discuss, formulate and recommend policy and strategic issues to the coordination committee
11. Work as assigned by the coordination committee, DoHS and MOHP.

Composition of Technical Committees

Technical Committee for IEC/BCC on Reproductive Health.

- ▶ Director of NHEICC-Chair person
- ▶ Section Chief, FP section/FHD- member
- ▶ Section Chief, SM section/FHD- member
- ▶ Representative, Population Division/MoHP- member
- ▶ Representative, WHO- member
- ▶ Representative, UNICEF- member
- ▶ Representative, UNFPA- member
- ▶ Representative, Save the Children- member
- ▶ Other Related Organization- Invitees Member as required
- ▶ Sr. Health Education Administrator, NHEICC-Member secretary

Technical Committee for IEC/BCC on Child Health

- ▶ Director of NHEICC- Chair person
- ▶ Section Chief, EPI section/CHD- member
- ▶ Section Chief, IMCI section /CHD- member
- ▶ Section Chief, Nutrition Section-Member
- ▶ Representative, WHO- member
- ▶ Representative, UNICEF- member
- ▶ Representative, Save the Children- member
- ▶ Other Related Organization- Invitees Member as required
- ▶ Sr. Health Education Administrator, NHEICC- Member secretary.

The above mentioned members will be regular attendees and related GOs/INGO/NGO development partners will be invited as and when needed. This committee will meet more frequently when needed.

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