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COMMUNICATION FOR BEHAVIOURAL IMPACT STRATEGY (COMBI STRATEGY):

CAMPAIGN TO PROMOTE ANTENATAL CARE WITHIN THE FIRST MONTH OF MISSING A PERIOD IN CAMBODIA

NOVEMBER 2007
(Revision: November 2008)

Jointly prepared by
National Centre for Health Promotion and
National Maternal and Child Health Centre

unicef
unite for children
Developed with joint support from the European Union and UNICEF

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November 2007
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PREPARED BY:

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- In consultation with relevant National Programmes within the Ministry of Health
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- Based on a 1st draft COMBI Plan/Strategy for Maternal and Neonatal Tetanus Elimination (MNTE) via Enhanced Antenatal Care in Cambodia, prepared by Dr. Everold Hosein (PhD), UNICEF Communication Consultant and Communication Advisor, WHO Mediterranean Centre for Vulnerability Reduction, Tunisia/Communicable Diseases Programme, Geneva

FOREWORD

The communication strategy of the campaign to promote antenatal care within the first month of missing a period covers a set of integrated communication activities that are targeting and aiming to benefit pregnant women and their babies. The behavioural objective, which is to encourage women to have their first antenatal visit within one month of missing their period, aims at improving the health of the mothers and their babies through the provision of iron/folate tablets, tetanus vaccination, pregnancy and other medical check-up as well as education on nutrition during pregnancy, all of which will contribute to the increase of child survival rates.

In order to achieve this behavioural objective, there is a need to develop an effective and strategic communication plan in accordance with a scientific and technical standard. In this regard, the communication plan was developed with active participation by different stakeholders from different levels, both national and local levels, by taking into account the local socio-economic and cultural context of Cambodia.

Moreover, the plan will serve as a guide to enable campaign implementers at all levels to understand clearly about the concept of behaviour change communication so that they can effectively focus their activities to support the behavioural objective, that encourage women to seek antenatal care early and on time so that they can enjoy a great benefit from the antenatal care package available at health centres all over Cambodia.

Phnom Penh, 20 November 2008

Dr. Lim Thai Pheang
Director of the National Centre for Health Promotion
Chairperson of the Campaign Management Committee

ACKNOWLEDGEMENT

On behalf of the National Centre for Health Promotion and the National Maternal and Child Health Centre, we would like to express our heartfelt thanks to specialists of the technical working groups of the government and development partners who have worked on developing this COMBI strategy of the campaign to promote antenatal care within the first month of missing a period. Since the beginning of this process the following organisations have offered their physical and intellectual strength and valuable time to develop this important strategy:

- National Maternal and Child Health Centre: National Immunization Program, National Nutrition Program and National Reproductive Health Program.

- National Centre for Health Promotion: Protocol and Guideline Team, Management Team, Information Team, Training Team and Monitoring and Evaluation Team.

- Provincial Health Departments of Kampong Speu, Kampong Thom, Prey Veng, Svay Rieng, Stung Treng, Mondulkiri and Udor Meanchey.

- Non-Governmental Organizations: UNICEF, UNFPA, WHO, MEDiCAM, RHAC, RACHA, BASICS and BBC World Service Trust.

We would like also to express our gratitude to the leadership of the Ministry of Health, the European Commission and UNICEF for providing full support to the development and implementation of the communication strategy of the campaign to promote antenatal care within the first month of missing a period in Cambodia, which is one of the main communication activities to promote maternal and child health in Cambodia.

Phnom Penh, 20 November 2008

Dr. Lim Thai Pheang
Director of the National Centre for Health Promotion
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1. OVERALL GOAL

To improve child survival rates in Cambodia by providing proper and early antenatal care to pregnant women, especially by providing medical check-up of the pregnancy, tetanus vaccination, provision of iron/folate tablets and offering health/nutrition education.

2. BEHAVIOURAL OBJECTIVE:

To encourage all child bearing age women (age 15-49) who are married or have sexual partner and who missed their menstruation/period to have their first ANC visit to the nearest health centre within one month of missing their period to receive a "package" of ANC services (ANC package includes: 1- confirmation of the pregnancy, 2- medical check-up of the pregnancy, 3- vaccination against tetanus, 4- provision of iron/folate tablet, 5- other medical check-up, 6- health/nutrition education). In this way we will have possibly pregnant women visiting ANC within one month of missing their period increase to 25% by December 2009 .

3. STRATEGY

3.1 The COMBI strategy here proposed is behaviourally driven: it focuses on that ultimate result of 25% possibly pregnant women visiting a health centre and meeting with a midwife or other appropriate health staff within 1 month of having missed their period. At this visit, the women will obtain a package of ANC health services (the package includes: 1- confirmation of the pregnancy, 2- medical check-up of the pregnancy, 3- vaccination against tetanus, 4- provision of iron/folate tablets, 5- other medical check-up, 6- health/nutrition education including pregnancy danger signs and immediate actions to be taken). The strategy presented below is based on some understanding of those factors which would hinder this behaviour and those factors which would facilitate it.

3.2 The COMBI strategy for the above behaviour needs to be informed by the available data and other insights as to why people would carry out the recommended behaviour, or not.

3.3 A review of field observations and conversations in Cambodia suggests that individuals will follow-through with the recommended behaviour if in their *cost vs. value* calculation they conclude that it is worth it to invest the effort and bear the "cost" in carrying out the behaviour in relation to the value of what they receive in return, and in relation to what other "competition" there is in the environment or "market place."

3.4 For many people, they see no value in the very early first visit for ANC. The fact that they have missed a period is no big deal; it is just a temporary internal imbalance, they believe.

And so they will wait, and wait, and wait.

3.5 Many are not aware of any particular advantages to visiting a midwife within the first trimester, much less 1 month after missing one's period. No one has provided them with information regarding the value of the very early first ANC visit. In many instances, people are not aware of the value of iron/folate tablets, or have even heard of it, or know that the folic acid contribution of iron/folate tablets is more effective when taken within the first 12 weeks of pregnancy. On the other hand, the extensive outreach immunisation activities have clearly prompted the value of tetanus vaccination.

3.6 Then there are instances, where people know the advantages but do not think the advantages are worth the effort to come in very early. They believe they can have the "value" of an early visit also at a late visit. In their minds, coming in within 1 month of missing one's period is no different than coming at 13 weeks or 15 weeks; the midwife will do the same things on both occasions. Their view is that whatever services they can get in the first month after missing their period, they can get later in the first trimester or even in the second trimester, and so they see no urgency to come in as early as is being recommended.

3.7 The pressures of other daily demands and the competitor of personal inertia or lethargy prevent one from taking immediate action even when one knows what the right thing to do is. It would seem that people need to be reminded of the value of an early visit to the health centre and be constantly triggered into action as a counter to lethargy.

3.8 In the case of having to start iron/folate tablets as part of the first ANC visit, others have shared the "side effects" of taking iron/folate supplements. So one is a bit hesitant of having to put up with these side effects earlier than necessary.

3.9 There is the time and effort involved in going to the health centre with no clear assurance that a midwife or appropriate health staff will be present. There is the travel distance between home and the health facility. There is the cost (money) for that first ANC visit. There is the re-scheduling of home tasks in order to have the time to make that first ANC visit. Transportation costs and opportunity costs, and time and effort, all add up in relation to what is gained from an early visit. We will need to engage possibly pregnant women in looking at the value side of the costs vs. value calculation. This is discussed later.

3.10 On the other hand, at least 50% of pregnant women see the value of coming for at least one ANC visit within the first six months of pregnancy, and about half of those within the first trimester. This proportion is closer to the behavioural objective in that they already come, and now the motivational engagement would focus on having them come in <u>earlier</u>. There is another portion who come in within the last trimester; they will need an extra motivational engagement to prompt a much earlier first ANC visit. However, moving them from coming late to coming early is also a challenge.

3.11 And then we have the more challenging group of about 30% who never receive any ANC care. The motivational engagement here is going to be quite substantial as it will need to explore the reasons for no ANC visit. One simple explanation is that for a certain proportion of this group, ANC services are simply not available. We do not know exactly what proportion has no access to ANC services. We will need to focus on that portion for whom ANC services are available but for whom there seems no special value in obtaining these services.

3.12 The costs vs. value calculation for the recommended behaviour will need to be carefully attended to in the communication strategy (all behaviour is chosen following an individual's calculation of the cost vs. value and the conclusion that the costs seem in harmony with promised value). One would have to present the health care package offered at the first early ANC visit as being wonderful even if it turns that one is not pregnant. But if it turns out one is pregnant, then the early start on these health measures (as part of the package) would provide an early start for a lovely healthy baby and a mother who will be around to care for that spectacular, miraculous child.

3.13 The messages need to address both the Head (logic) and Heart (emotional) dimension of the cost vs. value calculation. On the value side, we would need to point out that if you want to ensure against babies with congenital anomalies, then folic acid taken early in pregnancy as part of the iron/folate tablets will prevent malformation of the central nervous system, but that this needs to be taken early within those first 12 weeks. And there are other value items to be added: learning about better nutrition; learning to be watchful for danger signs and acting on them; being able to have the recommended 4 antenatal visits to ensure a safe birth and healthy baby.

3.14 In addition, we need to think of a modest incentive (a small gift of soap and a booklet about ANC placed in a very nice bag with campaign logo/branding) to be provided (as part of the communication effort and the ANC health care package) to every woman who comes in as recommended. A modest incentive offers a way of reducing cost burden and also giving a little extra value to the recommended behaviour. The recommended behaviour will also need to be branded; branding also adds perceived value to a behaviour or product.

3.15 The messages will need to be addressed in simple language the value of such things as iron folate/tablets, tetanus vaccination, and the critical time element to these, especially the first month for the folic acid component contribution of iron/folate tablets, plus an early start on birth preparedness, importance of delivering with skilled birth attendant and watching out for pregnancy danger signs. Women will act on the recommended behaviour if they are properly engaged in looking at the costs vs. value relationship of carrying out the recommended behaviour in relation to the outcome of a healthy, lovely child who will survive and a mother who will also survive to provide loving care. And, to repeat, we will need to address the cost vs. value calculation in relation to what alternatives or competitors there are. As they say in the business world, you do not know what something really cost until you have seen the alternative, even if the alternative is to "Do Nothing".

3.16 The discussion above offers the broad outline of what we can offer individuals in terms of the value of the recommended behaviour in relation to the "cost" involved in carrying it out and in comparison to doing nothing or just waiting for later. In this outline are the themes which will form the basis for engaged communication with a wide variety of people in Cambodia, both male and female, but with the ultimate focus being on the behaviour of the possibly pregnant woman.

3.17 A woman who has missed her period will carry out the recommended behaviour if she is:

3.17.1 Persuaded that getting folic acid as part of iron folate supplement early (i.e. within 12 weeks of being pregnant) will ensure that the baby has no malformations of the central nervous system; and that at that first ANC visit as recommended, folic acid will be given as part of the iron/folate tablets to be provided.

3.17.2 Convinced that getting adequate tetanus vaccinations prior to delivery will protect her baby from tetanus infection.

3.17.3 Persuaded that starting early on iron/folate supplementation will decrease anemia in her, give her more energy, and ensure a safer baby delivery; and that at that first ANC visit as recommended iron supplementation will begin if she is pregnant.

3.17.4 Assured that specifically mentioned side-effects of iron/folate supplementation (changes in the stool, etc) are minor and is worth the costs/burden in relation to the tremendous value/benefits gained.

3.17.5 Convinced that better nutrition for herself as a pregnant woman will make for a stronger and healthier baby and enable her to carry the pregnancy with greater ease and comfort and energy; and that at the early ANC visit recommended she will be given advice on how to start very early in her pregnancy on improved nutrition for herself an her baby.

3.17.6 Assured that the earlier she starts planning for the birth of her child, the better things will be and that part of the planning is to look out for danger signs and to act promptly on them.

3.17.7 Assured that when she makes that early first ANC visit as recommended she will receive a special gift for coming in (this promotion will be done in only 7 targeted provinces) .

3.17.8 Reminded wherever she turns that the branded recommended behaviour is the thing to do if she has just missed her period.

3.17.9 Reminded that health centre staff are trained and qualified and available and ready to welcome her with open arms and offer her the best care possible.

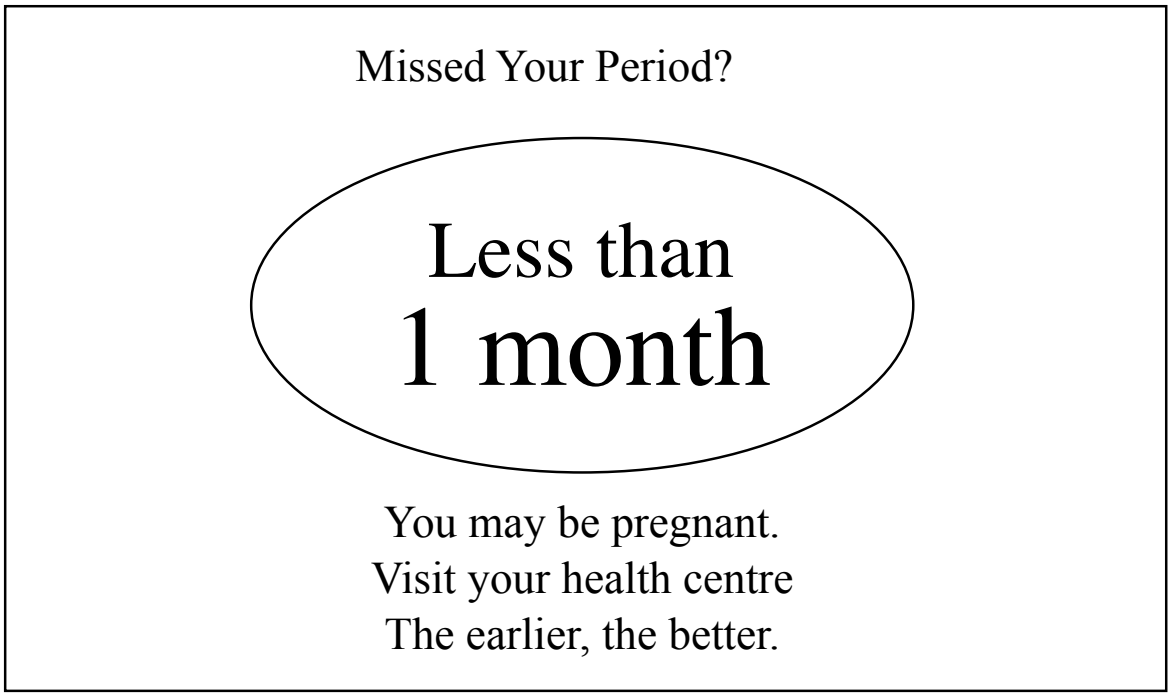
3.17.10 Reminded that what she really wants is to deliver a lovely, beautiful, healthy child and to be alive to hold, caress, love and care for her baby; that it does take some time when one holds with overvwhelming joy and love the miraculous baby in one's arms right after birth.

3.18 As we have mentioned, the above 10 communication themes are all part of the cost vs. value calculation which individuals carry out in deciding on behavioural options. Sometimes the calculation is not all logical; often emotions play a critical role; and human behaviour in any case remains a daunting mystery – we do the oddest things for strange reasons.

3.19 While the above-mentioned themes of the cost vs. value calculation will form the content of the "conversations" we need to have with the people of Cambodia as they consider the recommended early ANC visit behaviour, a favourable cost vs. value calculation, while necessary, is often not sufficient to prompt the desired behavioural response. People may know the right thing to do but still don't carry it out. People need to be triggered and nudged and encouraged to do what they already have calculated is the "right" thing to do. And some of these triggers can be provided by other family members, neighbours, friends, relatives, religious leaders, co-workers, and other community members. Here too lies the value of modest incentives and branding of the recommended behaviour.

3.20 Pre-Requisite: There is one pre-requisite which need to be stated upfront. Before this COMBI plan is implemented, there should be full assurance from the NMCHC Programme that all health centres throughout Cambodia (especially all health centres in 7 targeted provinces) are in a position to offer a basic package of health services as part of the first ANC visit within the first trimester of a pregnancy, and especially within the first month of a woman having missed her period; the "package" will include: 1- confirmation of the pregnancy, 2- medical check-up of the pregnancy, 3- vaccination against tetanus, 4- provision of iron/ folate tablets, 5- other medical check-up, 6- health/nutrition education including pregnancy danger signs and immediate actions to be taken.

3.21 The proposed COMBI plan focuses on the specific desired behavioural result indicated earlier and consists of an integrated, judicious mix of a variety of communication interventions responsive to the issues raised above.



3.22 One of the early actions required will be to brand the recommended behaviour: If you have missed your period, then within 1 month go to your health centre for your first "antenatal care" visit. The branding should consist of both a special logo and tag line/phrase. A graphic design firm should be selected to develop this logo/theme.

3.22.1 In English, one possible branding approach could be the following. A similar design in Khmer could also be done.

3.22.2 Cambodia has had a National Reproductive Health programme/strategy (RHP) for many years now. And most people seem to know about the recommendation to get some kind of antenatal care prior to delivery; about three-quarters do in fact get some kind of antenatal care. We suspect, however, that the RHP "brand" of ANC has gotten a bit jaded as many government programmes and commercial products do. And so too the general advice of receiving antenatal care. But because of this familiarity, people may more easily dismiss any new messages unless they stand out distinctively. As in the private sector, sometimes one needs to take an old brand of a product, make a some modest changes to the product (for example, with say Colgate toothpaste, add a teeth whitener chemical, give it a new "pumped-up"

name (such as Colgate Plus--Colgate +) and launch an effort which says we have something even better than the last time with the additional benefit of the teeth whitener. This sort of re-branding is now quite common in WHO and UNICEF where we have found new terms and logos to address old health issues such as malaria, TB, maternal and child health, etc. We need to do something similar to this behavioural recommendation of early antenatal care under the NMCHC umbrella.

3.22.3 The behavioural theme/logo should be simple and elegant in design, easy to duplicate and in two colours. The logo does not need to have any symbolic meaning in relation to antenatal care; by constant use it will become associated with the recommended behaviour, in the same way the "swoosh" of Nike which has nothing to do with athletic shoes has become associated with that brand of product over the years. Eventually one may wish to just use the logo by itself as a trigger for the recommended behaviour All communication materials, letterheads, folder etc, associated with this COMBI Plan should carry the logo and colours, even when associated with existing logos for the NMCHC, or NCHP, or the National Immunisation Programme. <u>The above Less Than 1 Month logo is merely suggested at this point but will be used henceforth in this document until an approved alternative is agreed upon.</u>

3.23 The key behavioural theme will then need to be put into some simple form to be used in all media and communication actions. The following is one such attempt and will need to be expressed in appropriate Khmer: "An important public message for Cambodian women – If you have missed your period, please come in within 1 month of missing your period and see a midwife at your local health centre. You may be pregnant. Start early to care for and love that baby. And remember: the earlier you start, the better for you and your baby"

3.24 We then go on to add in an extended version, and in intimate, effective Khmer-language:

3.24.1 "……You might be pregnant. And the ealier you find out, the better.There are two things we can offer you immediately which will make for a healthy pregnancy, safe delivery and a wonderful baby: (1) You start with iron/folate tablets early so that the folic acid part of these tablets can begin their work to prevent congenital malformations of the nervous system of the baby. This must be done in the first 12 weeks of pregnancy to have the best effect. Later the folic acid part of the iron/folate tablets will not work. So come in and get your iron/folate tablets early. The iron part of the iron/folate tablets prevents anaemia, and you know that most women in Cambodia are anaemic and this can lead to very serious complications in delivery if not taken care of; plus taking the iron/folate tablets gives you more energy during your pregnancy; (2) We will make sure that you and your baby are protected from tetanus infection. Many babies in Cambodia still die soon after birth because of tetanus, usually caused by unclean cutting of the umbilical cord and unclean care of the cord. We will make sure you have the right number of tetanus shots so that you and your baby are protected from tetanus infections and will inform you about the clean delivery practices

3.25 The above is suggestive of what can be said but basically we want to suggest the recommended behaviour and explain why in terms of cost vs. value it is worth carrying out the behaviour. It is an attempt to cover the key points in 3.20 above. Details of the messages, needs to be elaborated during the production phase by NCHP.

3.26 The heart of the COMBI strategy is what the private sector would call direct sale or personal selling: the door-to-door, face-to-face engagement of the consumer in his or her home. The mass media will also be used and will provide the backdrop for the more personal engagement which takes place between a "personal seller" and a woman. It is widely recognised that the ultimate key to action on a recommended behaviour is in the personal interactions between the consumer and a "seller". It is the personal communication between a woman who may be possibly pregnant and an ANC personal seller (to be called by a name as suggested below) which will be the primary means for prompting that early ANC visit and for making that first visit a memorable lovely visit. The COMBI plan will use the concept of personal sellers in two ways: one has to do with door to-door communication between a volunteer and a family of each home in Cambodia with regard to the behavioural theme, and the other has to do with personal care during ANC as conducted by midwives at each health centre. This will only be done in 7 targeted provinces.

3.26.1 Firstly, by a newly-branded core of some 4,400 volunteers (VHSG) to be called Mother and Child Health Missionary (MCH-M) each of whom will be asked right after the community launching to visit four homes per day/evening in their neighbourhood/village for a quick 15-minute home visit, and to repeat this quick home visit to the same homes four months later. Other than these home visits specifically intended for promoting the Less Than 1 Month behaviour, the MCH-M will be available in the village for helping a possibly pregnant woman who has missed her period to get to a health centre for her first ANC visit within 1 month of missing her period. Each MCH-M will be assigned a specific area and specific households in that area. At each home, the MCH-M will hand out a booklet, which covers the behavioural theme expressed above, in a nicely laid out presentation. It contains the basic behavioural message and rationale, with the key behavioural theme mentioned at least three times. There should also be a game/quiz of 10 multiple choice questions with some answers being humorous, to which a family member can try to answer. The correct answers will be at the bottom of the page upside down. Each household should get at least one booklet, even if there is no one of fertile age in the home. Grandmothers and older women can be useful, credible sources of information for others. The MCH-M will go over the basic behavioural theme of the booklet as she hands over the booklet and tries to emphasise the key behaviour recommended at least three times in the booklet.The MCH-M will focus on the recommendation of going to a health centre for that first ANC visit within 1 month of missing one's period. She will pay special attention to the cost/value decision-making process. And she will point out the small special incentive the possibly pregnant woman will receive when she go to the health centre for that first ANC visit; the incentive is part of a Pregnancy Welcome Kit given out at the health centre. The MCH-M will also stress that if any of the women should miss their period, they should immediately contact their MCH-M who will help them get to the health centre for that first ANC visit within 1 month of missing a period. She then urges family members (wives, husbands, in-laws) to try the quiz. The MCH-M also asks if they have any questions and sensitively responds to these questions.

3.26.2 As soon as a MCH-M is contacted by a woman who has missed her period, she should undertake a second home visit and engage the woman in arranging to make that early first ANC visit within 1 month. The MCH-M should be ready to

review any of the issues which may come up as part of the woman's cost vs. value calculation regarding the recommended behaviour.

3.26.3 These MCH-M will continue to be a counselling source to each woman who turns out to be pregnant. On average there will be one MCH-M per every 30 or so pregnant women, depending on household distribution per province. This converts to about 2-3 pregnant women/mothers per month; less than one per week on average. In addition to prompting the Less Than 1 Month behaviour, the MCH-M will be available for other mother and child health work. For example, they can continue to offer advice to the woman on taking the iron/folate tablets and dealing with side-effects. They can also offer advice on nutrition and help the woman watch out for danger signs. They can also facilitate and ensure delivery with the midwife or other skilled birth attendant. Later on they could be asked to counsel the woman on exclusive breastfeeding and may be asked also to focus on infant and young child feeding (IYCF) practices.

3.26.4 The MCH-M are not intended to be a new group of people/volunteers recruited. There is already a significant network of health volunteers at the village level which the MOH has spent several years building. The Community Based Baby Friendly Initiative has also used volunteers such as Model Mothers. In some places, these volunteers work very well and in other places not so well. Their role as volunteers has also become jaded in many communities. Some of them are quite tired. Some do very little community outreach. The MCH-M should be drawn from the current crop of volunteers in existence but using new criteria of selecting people. There should be two MCH-M per village, both of them should be preferably women. Priority should be given to VHSG, village chief, traditional birth attendance, community birth spacing volunteer and other available volunteers in the village. They should have indicated by their output a measure of commitment to community action. In the main, the MCH-M are likely to be women but men should not be automatically excluded. While current health volunteers cover a variety of health topics, the MCH-M (when wearing the MCH-M "uniform") will focus exclusively on mother and child loving care behaviours. On other occasions they may wear ordinary dress or another "uniform" and focus on other health behaviours. This is basically a re-branding of existing volunteers. The re-branding gives them a bit more status, embellishes their presence in the community, raises their profile, and presents a fresh face of some old health themes.

3.26.5 Each MCH-M will be given a special coloured jacket with campaign logo to wear on their home visits. If possible, each MCH-M should receive a personally addressed memo from the most senior MOH official (if not the Minister himself) requesting their keen participation in the home visit programme and thanking them for their past effort to provide excellent maternal and child health care.

3.26.6 Each MCH-M in groups of 20-25 will receive two-day non-residential training by their district health trainers and health centre midwife who will serve as their informal supervisor. The training should cover the key elements of the booklet; one day should be spent on all the technical information they need to be aware of; and the second spent on interpersonal communication and role playing in which each MCH-M plays the role of a household member and each plays the role of Missionary going through the process of engaging the wives and husbands and

in-laws in the discussion of the Less Than 1 Month behaviour.

3.26.7 The MCH-M will not be paid but they will be rewarded in various ways and provided with on going motivational social opportunities for sharing experiences. One gathering of the MCH-M will be held at district (OD) level, 9 months after the launch of the campaign. The total number of participant will be determined later in consultation with the district and provincial health staff. At the gatherings they will be thanked by the most senior district officer and provided with a special meal. They will also have an opportunity to share their experiences with their colleagues. Another gathering will be held at national level, 10 months after the launch of the campaign, most preferably in Kampong Som (a tourist city with beautiful beach). The certificates and thank-you events are small ways of expressing appreciation and motivating these committed MCH-M.

3.26.8 Secondly, by way of enhancement of the "Personal Selling" experience and personal care received by a possibly pregnant woman when she engages a midwife at the first ANC Less Than 1 Month visit. This involves in-situ in-clinic re-training of midwives by their district supervisors in the "human" dimension of personal care: how clients are greeted, and welcomed, and made to feel wonderful, especially if it turns out that the client is indeed pregnant. As part of the exchange between midwife and client is the handing over of a special Pregnancy Welcome Kit which will include simple gifts (soap and a booklet put in a nice bag). This should be given even a pregnancy cannot be confirmed. One might as well begin an appreciation for antenatal care from now. The kit becomes an additional part of the whole promotion activities and is expected to encourage other women to adopt the Less Than 1 Month behaviour. And the training of the midwife will include role playing sessions which allow them to practice going through the Kit with a client.

3.27 This "personal selling" will be supported by a media-based public relation campaign comprising a press activity and a short video.

3.27.1 The press activity will consist of a press release, covering key aspects of the behavioural messages and rationale. The press release will be given at the launch hosted by the highest possible MOH official, if not the Minister himself.

3.27.2 A short 5-minute video should be produced focused on messages and rational taken from the booklet. This can be a great complement to the TV/radio spots as it can provide more detailed explanation of the rational behind the Less Than 1 Month behaviour. It can be broadcast in various TV channels.

3.28 A national advertising campaign will also be an integral part of the COMBI plan. This is further detailed later in the plan. It will consist of a minimum of 8 three-week flights of advertising during the course of one year period, done in M-RIP (Massive, Repetitive, Intense, Persistent) style via radio, television and possibly newspapers. The national advertising effort is intended to keep on the public agenda the theme of Less Than 1 Month and generate mass reinforcing support for its practice, and to lend support for the door-to-door work of the MCH-M.

3.28.1 The campaign will consist of 8 three-week spurts (or flights), during the year, with radio advertising consisting of 60-second spots played every day during each flight, 9 times per day, television spots (60 seconds), played everyday during each flight,

6 times per day during prime time, and possibly full-page print advertisements during the first week of each flight. The advertising should be heavily discounted but they will be paid for to ensure broadcast of the spots at specific times and placement of print ads in pre-selected locations in the newspaper. All popular broadcasting facility should be used both government and private media.

3.29 Point-of-Service promotion should also form part of this COMBI plan. This will take three forms:

3.29.1 A Less Than 1 Month Flag done up in the colours of the new logo and with the new logo should be posted at each of the 150 health centres in the 7 targeted provinces where a possibly pregnant woman can go for care. The flag is not to be in the standard style of national flags but more in the shape of danglers, 50 cm by 150 cm, with the dangler hanging with the long end in vertical position. The flag becomes a visual reminder to people passing by that this is where they can come in for the Less Than 1 Month visit; this is where they should come within 1 month of having missed their period.

3.29.2 In each health centre, in the waiting area, there should be three large posters prominently displayed which messages similar to those of TV/radio spots.

3.29.3 In the midwife's room, there should also be the same three posters, as reminders to the midwife and the woman.

3.30 The "Welcome to Pregnancy" Kit and Midwife/Client Communication at the first ANC Less Than 1 Month visit: This first visit is the most critical of all the visits by the possibly pregnant client to the midwife's office. What happens here is central to all the other behaviours we may wish to recommend for improved maternal and child health. A special Welcome to Pregnancy Kit should be produced, which will contain a piece of soap and a booklet about ANC placed in a very nice bag with campaign logo/branding. The booklet should cover the benefit of iron/folate tablets, tetanus vaccination, nutrition during pregnancy and the danger signs. The kit should have a congratulatory feel to it. It should be presented with joy and a congratulatory exclamation from the midwife to the client. If it is not yet possible to confirm pregnancy, the midwife should invite the woman to return to check on whether she is in fact pregnant. For all women, the midwife should conclude by setting a time for the next visit.

3.31 The COMBI plan will begin with administrative mobilisation (official memoranda/circulars from the Minister of Health and other senior officers, and associated staff meetings) and directed at engaging all MOH staff at all levels (the central, provincial, district, and including the lowest level staff, such as cleaning staff) in Cambodia, to actively participate in this COMBI effort for Less Than 1 Month early antenatal visit.

3.32 The COMBI plan will be managed by a Campaign Management Committee comprising high level officers from the National Centre for Health Promotion, the National Maternal and Child Health Centre, representative from UNICEF, WHO, UNFPA, and other concerned NGOs. The Committee will be under the chairmanship of NCHP and NMCHC. One senior staff member of NCHP should be designated as the person responsible for coordinating day-to-day execution of the programme. This COMBI Coordinator will be supported by a UNICEF programme officer. The Committee will meet regularly every two months (but ad hoc meetings can be called as necessary) to coordinate implementation and to monitor

implementation progress.

3.33 Monitoring and evaluation: This will take various forms:

3.33.1 Monitoring of activities implemented by MCH-M will be randomly monitored by staff from district and provincial level, and occasionally by NCHP staff. Health centre staff and/or midwife should also participate in this monitoring.

3.33.2 In addition to the above monitoring activity, more feedback can be obtained from MCH-M during various thank you ceremonies held at district level as well as at central level.

3.33.3 Small tracking surveys of mass media activity will be carried out twice during the mass media campaign (mid year and end year) in the 7 targeted provinces. This will track exposure to and comprehension of the behavioural theme, and any emerging behavioural responses. M&E team of NCHP will conduct the surveys.

3.33.4 Impact evaluation will be done through a baseline and endline surveys about health centre utilization (number of women visiting health centre within one month of missing their period) which should be selected from selected health centre in 7 targeted provinces and other control provinces. The data collected can be compared to show the impact on the recommended behaviour. The NMCHC will ensure that each health centre is capable of tracking and recording this basic information regarding the timing of the first ANC visit, in relation to the behavioural objective of this COMBI plan. Details of this impact evaluation need to be developed further by NCHP's M&E team.

3.34 It is widely acknowledged in the private sector world of integrated marketing communication, the consumer communication world, that behavioural responses are possible only with a smart blend of mass media, personal selling/interpersonal communication, promotional triggers and related public relations/advocacy. The COMBI plan as detailed below may seem an excessive and messy blend. But it follows the recommended style of M-RIP: Massive, Repetitive, Intense, and Persistent. And all of it is necessary. In marketing communication experience, there is the view that to have behavioural impact, an individual needs to be "hit" with the behavioural message about 6 times per day over several days per week over several weeks. The above strategy should lead to the following "hits":

An individual will get the Less Than 1 Month behavioural message from the media advertising, from a poster and banner in the health centre and in the village, from the home visit by a MCH-M, from a flag at each health service point, from a booklet, from a family member or neighbour who would have seen/heard the behavioural message from some sources.

Non-COMBI specialists are likely to be tempted to eliminate several communication interventions if budget crunches appear. It is important that, if there is a budget crunch, decisions on what blend of communication interventions to retain be made by COMBI specialists in close consultation with the NCHP/NMCHC and UNICEF staff. In addition, we should avoid the temptation of carrying out the programme in piece-meal fashion, meaning that we'll do some personal selling this month, and then sometime later we'll have a press conference, and then later in the year we'll do some advertising, etc. Ideally, this

integrated plan should be synchronised and strategically implemented so that the different pieces providing reinforcing support to each in a timely fashion.

4. COMMUNICATION ACTIONS

(Note: Each of the actions below will require their own implementation micro plans; in preparing the detailed work plan, under each activity, one should therefore insert a line for developing the micro plans.)

4.1 CAMPAIGN LOGO/BRANDING OF EARLY ANTENATAL CARE VISIT LESS THAN 1 MONTH

4.1.1 Design a new logo and branding them for the recommended behaviour. See guidelines in section 3 above. This is to be used on all materials dealing with this COMBI plan in Cambodia.

4.1.2 A local design firm will be contracted to do this assignment.

4.2 ADMINISTRATIVE MOBILISATION AND PUBLIC RELATION

4.2.1 Prepare a one or two-page briefing paper in MoH announcement format with the Less Than 1 Month logo signed by the Minister of Health. The announcement should describe the new thrust in antenatal care in Cambodia, the behaviour to be promoted and should seek support from all MoH staff and concerned NGOs in order to have a successful campaign. The announcement should begin with an expression of appreciation for the past work done on antenatal care by health staff but drawing attention to the remaining challenges, and calling for continued vigorous support of the COMBI initiative focused on the specific desired behavioural outcome. The briefing announcement is to be distributed to all staff at all levels in the MOH and all concerned NGOs. The total quantity of the announcement to be printed will be identified with NCHP.

4.2.2 Issue an official memorandum from the Director of the NMCHC on the COMBI plan and the expected help of each midwife to be addressed to each midwife, explaining the rationale for the plan and requesting their involvement and support, specifying the actions they will need to take when someone comes in for their first ANC visit as recommended, and their role as trainers/supervisor of MCH-M. The memo will be distributed at the step-down training to health centre staff (including health centre midwife).

4.2.3 Organize a half day campaign launching at central level, presided by the Minister of Health or a senior official from the MoH at a five-star hotel in Phnom Penh. People to be invited to the launch include all members and chairperson of the Campaign Management Committee, all concerned National Programmes, two health officials from each of the total 24 provinces in the country (one should be the director or vice-director of the provincial health department in charge of health promotion; the other should be the head of the provincial health promotion unit), all concerned NGOs and UN organizations, and the media. The MoH announcement should be

distributed to all participants in order to secure commitment for implementation, with a special focus on the help expected of all health staff in sharing the behavioural messages. Each Provincial Health Director or Vice-Director will be asked to ensure that the announcement is circulated throughout the provincial health system and that regular staff meetings at all levels (and incorporating all staff, including cleaning and building maintenance staff) include the Minister's announcement on the agenda for discussion. A press kit comprising press release and background documents including general information on maternal and child health in Cambodia, will be distributed to the media at that time.

4.3 COMMUNITY MOBILIZATION

4.3.1 Organize community launching of the campaign following the launch at central level. Depending on the capacity of district health office and health centre, community launching should be done in selected OD in the 7 targeted provinces. The total number of participant should be around 200-300 and should include health centre staff, OD staff, PHD staff, one MCH-M per village, concerned local authority, teacher and student. IEC materials for community launching will comprise booklet, poster, banner, T-shirt and cap. A march will be organized to go around the village with all participants wearing the same T-shirt and cap, equipped with loud speaker, banner, local traditional dancing team (Cha Yam) and stop at one point where a ceremony is held with a senior district or commune official delivering a speech. Flyer should be distributed to everyone met during the march or joining the launch. Posters are placed in different strategic locations in the village and at the launching site. There should be a stage to play a live music band or a comedy right after the official launch. Questions and answers on the early ANC visit Less Than 1 Month should be inserted in the play by health centre or OD staff with small prices to be given to those who can correctly answer the question.

4.3.2 Media (TV, radio and print) will be invited to cover the community launching in some selected location.

4.3.3 Produce a 5-minute video focused on the behavioural theme and rationale, and distribute to all television stations for broadcasting.

4.4 PERSONAL SELLING/DOOR-TO-DOOR COMMUNICATION

4.4.1 Mother and Child Health Missionary (MCH-M) Home Visits

4.4.1.1 Present COMBI plan to provincial and district health senior officers responsible for the campaign in 7 targeted provinces and discuss/review planning for interpersonal communication and other communication activities at community level. This will be done by NCHP staff.

4.4.1.2 Develop training materials by conducting training need assessment and develop appropriate training curriculum for training of trainer to PHD and OD staff (to be implemented by NCHP staff) as well as for step down

training to health centre staff and MCH-M.

4.4.1.3 Conduct training of trainer to PHD and OD staff by NCHP staff. There should be 2 people from each PHD and 2 from each OD. This needs to be discussed during the presentation of COMBI plan with provincial and district health senior officers in the 7 targeted provinces mentioned above.

4.4.1.4 Conduct step down training to health centre staff. The training will be conducted by PHD and OD with support from NCHP. Participants of the training comprise 2 people (1 health centre director and 1 midwife) from each health centre. Then, OD and Health centre staff with support from PHD will conduct training to MCH-M (2 MCH-M per village). The number of participant in each training should be around 20-25. The training should be done at the health centre for a period of approximately 2 days. Lunches and tea/coffee breaks will be served for the MCH-M. At the training, each MCH-M will be given their jacket and IEC materials (posters, booklets and banners).

4.4.1.5 Design and produce about 4,400 coloured light cotton "waist vests" (a sort of jacket which one wears over a shirt or dress, like the safety vests some police/traffic officers wear but not necessarily in that expensive fluorescent material), emblazoned with the Less Than 1 Month logo and the MCH-M title. These are to be given to the MCH-M to wear when they make their home visits.

4.4.1.6 Write, design and print a booklet (quantity to be discussed later) with content as described in Section 3 above, with the focus on the behavioural message and rationale. These are to be distributed door-to-door by the MCH-M.

4.4.1.7 Design and print about 4,400 Certificates of Appreciation, to be electronically signed by the Minister of Health, to be given out to the MCH-M at the Thank You ceremony to be held on the 5th month after the official campaign launching. It should be noted that this should be further discussed with the MoH to look at the capacity and practicality of doing it.

4.4.1.8 Arrange for the home visits by the MCH-M to begin right after the community launching, at the same time throughout the 7 targeted provinces.

4.4.1.9 Arrange for the second round of home visits four months later.

4.4.1.10 Hold a Thank You Ceremony at the district (OD) level, 5 months after the launch of the campaign, under the auspices of PHD and NCHP senior staff. Thank the MCH-M for their home visit work and continued support, distribute certificate of appreciation, and invite them to share their experiences and challenges. A lucky draw will be conducted to select 2

MCH-M per province to join the central level Thank You Ceremony to be held in Kampong Som. Tentatively, participants selected from each province to join the central level ceremony will comprise 2 MCH-M, 2 staff from a health centre (1 midwife and 1 health centre director), 1 staff from an OD and 1 staff from PHD.

4.4.1.11 Hold another Thank You Ceremony at central level (Kampong Som).

4.4.2 Midwife/Client Communication at the first ANC Less Than 1 Month Visit and the "Welcome to Pregnancy" Kits

4.4.2.1 Design and produce plastic pin badge (quantity to be discussed later), in the logo colours and with the logo to be given to all midwives in the 7 targeted provinces, who will wear it at work.

4.4.2.2 Arrange for preparation, design, production and distribution to health centres of "Welcome to Pregnancy" Kits (quantity to be discussed later), as described in Section 3 above.

4.4.2.3 Arrange for an official memorandum from the Director of the NMCHC on the COMBI plan and the expected help of each midwife to be given to each midwife and Health Centre Director (copied to appropriate others), explaining the rationale for the plan and requesting their involvement and support, specifying the actions they will need to take when someone comes in for their first ANC visit as recommended, and their role as trainers/ supervisor of MCH-M. The memo will be distributed at the step-down training to health centre staff (including health centre midwife)

4.4.2.4 Arrange for random monitoring of health centres to examine the work of midwives with regard to the early ANC visit Less Than 1 Month.

4.5 ADVERTISING

4.5.1 Plan and execute an M-RIP (Massive, Repetitive, Intense, Persistent) Radio, TV and possibly newspaper advertising campaign.

4.5.2 Make arrangements for selecting an "advertising agency", including sending out a creative brief (based on this COMBI plan).

4.5.3 Confirm "flight" scheduling of campaign allowing for 8 flights of three weeks duration (will use 3 spots for the first 6 months and 3 other spots for the last 6 months) during the course of one year with breaks/pauses between the flights of 1 month (The advertising campaign will be carried out in "flights" over the one-year period. A flight is defined as that period of time during which the advertisements take-off or are run (say three weeks-1 month), followed by a pause of several weeks (about 2-6 weeks), and then followed by another flight of another three weeks-1 month, another pause, and so on. Strategic and constant repetition is

key in advertising. The ads, reinforcing each other in each medium, will reach key opinion leaders (KOLs), who in turn further disseminate the messages and stir interpersonal chat)

4.5.4 Confirm agreement on style of advertising. The electronic media advertising should avoid excessive creativity, gimmickry and frivolity (excess of music, dance, cleverness, etc.). We are dealing with serious themes and while some humour/music can be there, the advertising should have the air of an intimate conversation with the listener/mother, husbands, in-laws, grandmothers, especially the rural listener, an act of engaged communication. Simple, elegant production values are needed. These spots should be earnest, calm, very intimate chats with the audience. On radio and TV one is always communicating with just one other individual. Intimacy is important for the critical subject of pregnancy and mother-child loving care. The content of all the ads should focus on the behavioural response being sought with precise and intimate explanation of why the behaviour is being recommended.

4.5.5 Develop content of the advertisements for radio, television, newspapers with reference to the themes of Section 3 above. The advertisements should focus sharply on the behavioural theme and the rationale for the behaviour. The behavioural theme should be stressed at least three times in each ad.

4.5.6 Produce 60-second version for radio and television advertisements, and full-page and half-page for newspapers. It may be necessary to produce six different spots for radio and TV in order to incorporate the key themes listed in Section 3 above.

4.5.7 Arrange for placement of ads on radio-television, and newspapers. In the first 4 flights, three 60-second radio and television spots should be used. Radio spots should be scheduled for 9 times per days, and TV spots 6 per evening prime time. In the last 4 flights, the schedule should remain the same except that 3 new spots may be used on radio-TV.

4.5.8 Monitor implementation of radio-television-newspaper advertising and make adjustments depending on public feedback and results of small tracking surveys (described below under "Impact Evaluation").

4.6 POINT OF SERVICE PROMOTION

4.6.1 Produce Less Than 1 Month Flags/Danglers (0.5m x 1.5m) as described in Section 3 above and arrange to have these danglers/flags flown at each health facility providing antenatal care (3 flags per health centre to be changed every 6 months, equal to 6 flags/health centre)

4.6.2 Produce one set of 3 different posters on the behavioural theme and focusing on the three messages as in the 3 TV/radio spots as described in Section 3 and arrange to have these posters placed at the health centre (2 sets per health centre, to be changed every 6 months, equal to 4 sets per health centre). The posters should also

be given to MCH-M for display in the village (10 sets per village, 5 sets for first display and the other 5 for replacement 6 months later)

4.6.3 Produce banners (0.8m x 4m) and distribute to health centre. Each health centre will receive 1 banner. The banner will be placed outside the health centre or at its entrance. The banners should also be given to MCH-M (1 per village) for display in the village.

5. MONITORING AND EVALUATION

5.1 Arrange for random check by NCHP for the activities carried out by PHD, OD and MCH-M.

5.2 Arrange for random check by PHD and OD for the activities implemented by health centre midwife and MCH-M. For the monitoring of MCH-M's work, midwife or health centre staff/director should be involved.

5.3 Arrange with OD staff to get feedback from MCH-M at the Thank You ceremonies at OD level and also at central level.

5.4 Conduct small tracking surveys of mass media activities twice a year (mid year and end year) in the 7 targeted provinces. This will track exposure to and comprehension of the behavioural theme, and any emerging behavioural responses. M&E team of NCHP will conduct the surveys.

5.5 Conduct health centre utilization surveys twice (one at the beginning of the campaign and another one near the end of the campaign) to document the number of women visiting health centre within one month of missing their period. This should be done in selected health centre in 7 targeted provinces and in other control provinces. The data collected can be compared to show the impact on the recommended behaviour. The NMCHC will ensure that each health centre is capable of tracking and recording this basic information regarding the timing of the first ANC visit, in relation to the behavioural objective of this COMBI plan. Details of this impact evaluation need to be developed further by NCHP's M&E team.

6. COMBI PROGRAMME MANAGEMENT AND WORK PLAN

6.1 MANAGEMENT

6.1.1 The COMBI plan will be managed by a Campaign Management Committee comprising high level officers from the National Centre for Health Promotion, the National Maternal and Child Health Centre, representative from UNICEF, WHO, UNFPA, and other concerned NGOs. The Committee will be under the chairmanship of the NCHP. One senior staff member of the NCHP should be designated as the person responsible for coordinating day-to-day execution of the programme. This COMBI Coordinator will be supported by a UNICEF programme officer. The Committee will meet regularly every two months (but ad hoc meetings can be called as necessary) to coordinate implementation and to monitor implementation

progress

6.1.2 Appoint the Campaign Management Committee

6.1.3 Schedule and hold regular meetings (and ad hoc meetings when necessary) of the Campaign Management Committee.

6.2 WORK PLAN

6.2.1 The above list of communication and managerial actions in Section 4, 5, 6 will be laid out in a detailed implementation work plan with appropriate scheduling of activities and identification of persons responsible for implementation at all levels. It is resulted from a series of workshops and discussion with NCHP, NMCHC (including National Nutrition Programme, National Immunization Programme, Reproductive Health Programme), other UN agencies and NGOs concerned. The above activities will be repeated below in Annex 1 as a tentative Work Plan but laid out in landscape format with columns for designating persons responsible and setting time lines.

Annex 1: Campaign Workplan
COMBI Plan to Promote Early Antenatal Care

Activities	Responsible	2007		2008												2009											
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1. Campaign logo/ branding design	NCHP									X	X																
2. Administrative mobilization																											
Memo from MoH	NCHP									X	X	X	X														
Memo from NMCHC	NCHP									X	X	X	X														
National compaign launching	NCHP															**X**											
3. Community mobilization																											
Community campaign launching preparation	NCHP									X	X	X	X	X													
Community campaign launching	PHD-OD															X	X										
4. Personal Selling (door to door communication)																											
Presentation of COMBI plan to 7 provinces	NCHP		X																								
Develop trainning materials	NCHP					X	X	X	X	X																	
Training of trainer (Participants:PHD+OD)	NCHP										X	X															
Step down training - To HC staff - To MCH-M	PHD-OD													X	X												

Activities	Responsible	2007		2008												2009											
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Home visit by MCH-M	MCH-M																X	X					X	X			
Thank you ceremonies and feedback at district level	OD																								X		
5. Advertising																											
Production of TV and radio spots and a karaoke documentary	NCHP-UNICEF										X	X	X	X	X												
Broadcast of TV spots and a karaoke documentary	NCHP-UNICEF															X	X		X	X		X	X		X	X	
Broadcast of radio spots	NCHP-UNICEF															X	X		X	X		X	X		X	X	
Advertisement in newspapers and magazine	NCHP-UNICEF															X	X		X	X		X	X		X	X	
6. Point of service promotion																											
Production of “welcome to pregnancy kit”	NCHP										X	X	X	X													
Production of flag	NCHP-UNICEF										X	X	X	X													
Production of banner	NCHP-UNICEF										X	X	X	X													
Production of poster	NCHP-UNICEF										X	X	X	X													
Distribution of IEC materials	NCHP-UNICEF														X												
Production of plastic pin badge	NCHP-UNICEF										X	X	X	X													
Production of T-shirt and cap	NCHP-UNICEF										X	X	X	X													

Activities	Responsible	2007		2008												2009											
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Production of booklet	NCHP-UNICEF										X	X	X	X													
Production of jacket for MCH-M	NCHP-UNICEF										X	X	X	X													
7. Monitoring and Evaluation																											
Random check by NCHP of the activities carried out by MCH-M and PHD-OD	NCHP-M&E																X	X					X	X			
Random check by PHD and OD of the activities carried out by MCH-M	PHD-OD																X	X					X	X			
Small tracking surveys of mas media activity	NCHP-M&E																		X						X		
Thank you ceremony and feedback (see above)	NCHP																								X	X	
Health centre utilization surveys	NCHP M&E											X	X	X										X	X	X	
8. Programme management																											
Establish a COMBI Management Committee, Focal Point and members.	NCHP	X																									
Hold regular meeting (every 2 months)	NCHP	X		X		X		X		X		X		X		X		X		X		X		X		X	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