



Integrated Maternal, Newborn and Child Health (IMNCH)

**Behaviour and Social Change
Communication Strategy**



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Summary Overview

Title	Behaviour and Social Change Communication Strategy to accelerate Maternal, Newborn and Child Health
Goal	To empower families and communities with the information, skills and tools they need to make critical informed choices and take action to ensure the health and general wellbeing of mothers, newborns and children under 5 years old
Objectives	by December 2015, to: i. increase the number of women of child bearing age that can state the benefits of at least 3 maternal, 3 newborn and 3 child health practices ii. increase the practice of appropriate behaviours for maternal, newborn and child health at home (including health seeking behaviours) iii. increase the number of Health Educators and community-based counselors that have the capacity and tools for effective counseling and public education iv. increase the number of primary health care facilities implementing standard client-friendly counseling services v. Increase the number of functional Community Development Committees holding regular (monthly) community dialogues vi. increase the number of networks and structures that support IMNCH activities vii. generate data and evidence to inform IMNCH and behaviour and social change programmes and policies
Outcome Milestones	i) 75% of family caregivers have understand the importance of and have skills for appropriate maternal, newborn and child care in the home ii) 55% of family caregivers practice appropriate maternal and child care including facility visits for preventive and curative health iii) Health workers provide effective counselling in facilities, at home and during community events iv) Community structures and leaders (traditional, religious, female and youth) support sustainable practice of critical behaviours through regular updates of health information Boards, community dialogues and collective action v) Partners and networks (incl. faith-based institutions, professional bodies, private sector) undertake activities that reinforce critical maternal, newborn and child Facts for Life and within families and by communities vi) the IMNCH communication strategy is supported by a monitoring system vii) Lessons and approaches from the IMNCH communication strategy integrated into partner programmes and government policies
Strategic Principles	i) Integration using multiple opportunities ii) partnerships for harmonization and rapid roll-out iii) pre-and in-service training of service providers for sustainability

and support development of plans of action at sub-national levels. It shall ensure compliance with the guiding principles of the communication strategy, especially that the process of implementation be owned and driven by community persons and institutions.

Social Mobilisation Technical Committees: The Social Mobilisation Technical Committees (SOMTECs) shall coordinate communication support to IMNCH at the state, LGA and community levels. The committee comprises technical officers and communication specialists from all sectors. Its expanded membership should include Community Development Officers (CDOs) at the LGA secretariat and prominent traditional and religious leaders, service providers, private sector personnel and civil society groups. The Chief Health Educator and the Information Officer in the Ministry of Health should provide joint technical guidance to the group. The CDO and LGA Health Educator, civil society groups and traditional institutions should be the links to communities, to provide required capacity update, tools and technical inputs to the community-led processes that address implementation of the Strategy. They should, specifically, address gaps in the existence and operations of the Community Development Committees, especially the participation of all groups, notably children, youths and women.

Feedback and Interaction Systems: The coordination system recognizes the need for regular feedback among all structures in the system. Periodic meetings will be held at state, zonal and national levels to discuss progress in implementation. Information shall be shared continuously in the course of work at all levels of coordination. For example, feedback related to communication in NCH and ICC meetings shall be shared with the CTC and the Working Group. These will also be shared to sub-national level structures who will also share products of their meetings and work with national-level structures.

It is important to note the linkages with the Resource Mobilisation and Monitoring and Evaluation Working Groups. Funding and evidence are a critical component of communication support to IMNCH. The partnership will continue to interact with these groups, share information and request technical support as appropriate. Data generated by the M and E group would be required to fine-tune programming content and context. **Figure 2** clearly identifies feedback processes and positions the other working groups as veritable partners in IMNCH.

Advocacy

For the project, advocacy will be done at all levels, national, State, LGA and community levels to engage the policy makers and key gatekeepers to create the enabling environment for behaviour adoption and sustained practice.

Firstly, is to ensure that quality and timely services can cope with increasing demand by

- making available the financial and human resources for efficient and effectively delivery of services
- by actually monitoring and requesting for regular updates from Commissioners (e.g. in the case of Governors) and from Directors at the LGA level.

Secondly is to ensure that the public rhetoric of policy makers are consistent with the practices being promoted e.g. they also have their children vaccinated during every round of Immunisation Plus Days. At the Community level advocacy efforts will target the Community Development Committees/Associations to ensure they participate meaningfully in the delivery of health services for actual ownership which is expected to translate into increased utilisation.

Chapter 6 Monitoring, Evaluation and Documentation

Monitoring will be anchored on the existing systems of the Federal Ministry of Health including any specific reporting system developed to support the roll out of the IMNCH strategy. Joint assessments, reviews, monitoring and reporting will be carried out on all of these elements at community, facility, LGA and state levels to ensure linkage and synergy of interventions.

- final evaluation and analysis will take into consideration the impact on key indicators and the integration of high impact interventions on child survival

Specifically at the community level, monitoring will be linked to the regular updates of the Community Health Information Boards,

% of parents of under five year old children that can correctly state the benefits of at least 3 key household practices in the target LGAs

% of parents of under five year old children that report correct application of at least 3 of the key household practices in the target LGAs

At State level, a survey is to be conducted to serve as baseline. In selected LGAs a simplified survey of the key indicators will be collected, and repeated at the end of a 12 month period. State surveys will be repeated in 2-3 years. In addition, specific monitoring activities will be carried out as follows:

1. at the state level, quarterly reviews of process indicators for planning, service delivery and community engagement and participation
2. at the LGA level, monthly report on key progress indicators and preparation of summary reports for state monitoring figures
3. at the health facility level, weekly progress updates by the health facility and community teams, monthly summary figures for further collation and review at LGA level
4. at the community level, weekly review of key progress indicators and update of community information boards
5. mid-year analysis in states and rapid review of the programme progress indicators including coverage figures
6. at the end year, LGA and state survey of achievement of the key results
7. media monitoring at sentinel sites

The final documentation and impact analysis will be reviewed at state level to draw lessons learnt, assess impact on achievement of key results and implications for scaling up of high impact interventions.

State and LGA dissemination plan design and implemented with involvement of other stakeholders and communities.

Specifically, the results will inform:

- How tools such as the Community Health information Board can be used at LGA level?

- What do LGAs, ward and traditional leaders need at minimum to be effective in revitalizing primary health care services and their use?
- What C4D strategy improves key household practice and service use uptake?
- What is the cost of LGA-wide health promotion and communication service actions?
- What community structures and methods foster community participation and ownership?
- How to and at what cost can community-based health information systems be set up and how to link this with maternal, newborn and child care improvement strategies at community level?

These answers will inform state-wide scaling up, help state government's prioritize and budget for appropriate interventions and develop capacity in State and LGA governments as well as other institutions in communication analysis and evidence-based planning.

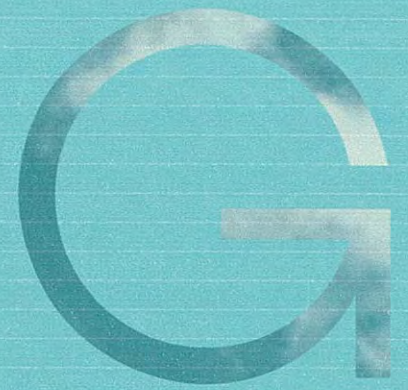
Measuring of the results will be done through analysis, evidence generation and evidence-based planning experience will be an integral part of the strategy. There will be capacity development towards this, to enable these skills to be used for rapid state-wide scaling up later. Specifically the strategy will emphasize:

- data on utilization of health services e.g. routine immunization, antenatal attendance will demonstrate progress
- local Health facilities system data will indicate trends with defaulter tracing, home visits for counseling as well as trends with maternal and child morbidity and mortality
- community health information boards will show immediate gains for children in the household at community level
- monitoring of the reach and recall of the media messages

Components of the budget

	Specific areas/results	Responsible partner
Health Facility		
	Functionality assessment, situation analysis and rapid baseline survey (Health Facility, including health promotion units at national, State and LGA levels)	
	Support for initial IMNCH introduction design sessions and planning by Core Technical Committee to the states	
	Facility based functionality/ capacity development and tools to support IMNCHcom implementation.	
	Support for defaulter tracing and home-based counseling in collaboration with health teams	
Multi-media campaigns		
	Market research to brand the media campaign series, conduct message, audience analysis and formative research	

	Script writing, production and airing costs of 52 weeks radio drama series that deliver key messages on maternal, newborn and child health	
	Reproduction to support groups/community dialogues (in 3 key dialects)	
	Training of resource persons to manage the airing and facilitation of radio interactive programmes after message airing	
	Production and airing of Nigeria IMNCH television series (with Nollywood)	
Behaviour Change Communication		
	Community mobilization - Health information boards - community dialogues, - messaging by Town Announcers, - activities by community-based organisations - activities by faith-based groups/facilities	
Partnership-based activities		
	Advocacy and promotional activities with professional bodies	
	Youth-based promotional events thru sports and with celebrities	
Monitoring, Evaluation & Documentation		
	Participatory situation analysis, rapid baseline survey and development of community profiles (for select sentinel sites)	
	Monitoring & supervision costs to track key indicators in sentinel sites	
	Consultant national institution to supervise the communication component of the project	
	Institutional fees for the operational research and monitoring component	
	Monitoring and Evaluation and generation of evidence	



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	iv) of improved practices inclusion, participation and self determination by communities for an enabling environment for behaviour change
Core Platforms	i) Behaviour change counseling at facility, group, and home ii) Capacity development for service providers, communities and partners iii) Community support – health information boards, dialogues, local theatre, community viewing and listening, mobilisation during special events iv) Monitoring, evaluation and documentation
Indicators	By December 2015 At the individual and household level i) Progressive increase in knowledge and understanding ii) Changes in perceived risk, beliefs, subjective norms iii) Changes in attitudes and intentions iv) Improved skills and practices v) Improved self image, social influence At the community and societal level/social change indicators vi) Equity in participation vii) Increasing engagement, empowerment viii) Information sharing equity ix) Sense of self-determination and ownership x) Increase in social cohesion xi) Change in social norms
Participant Groups	Primary: pregnant women and mothers with under 5 year old children Secondary: - other family members – husbands, mothers-in-law, children - religious and traditional leaders - peer and community social groups - health workers, TBAs, and community counselors - community influentials

The IMNCH Programming Context

In 1990 the United Nations General Assembly agreed on key global goals to address the general development and wellbeing of nations across the world. Several of these Millennium Development Goals (MDGs) relate to the reduction of malnutrition, reduction in morbidity and mortality and addressing specific diseases like HIV/AIDS, malaria and tuberculosis.

By 2003 the Lancet medical journal published findings on key high impact household practices that can help to drastically reduce morbidity and mortality levels through simple double actions at the household and community levels.

In 2007, the Government of Nigeria launched the Integrated Maternal, Newborn and Child Health Strategy to facilitate the implementation of high impact and cost effective interventions to accelerate progress towards achievement of MDG goals 4 and 5 and contribute to the achievement of MDGs 1, 6, and 7.

This IMNCH Behaviour and Social Change Communication Strategy provides a framework to guide Government practitioners and development partners in their interventions to remove the socio-cultural and related bottlenecks to full utilization of existing services, participation and ownership in the delivery of basic health services.

The IMNCH Behaviour and Social Change Communication Strategy is a holistic approach to the reorganization and reorientation of the health and community communication systems to ensure delivery of high impact, evidence-based, essential set of interventions which will provide a continuum of care for women and children. The strategy articulates the role of individuals, households and communities in creating and sustaining positive healthy behaviours and attitudes that enhance child survival and development and wellbeing of women

Process of developing the IMNCH behaviour and Social Change Strategy (ONE PAGER- TO BE DEVELOPED)

- ref to national health promotion strategy
- ref to child survival com strategy
- ref to Reproductive Health strategy
- ref to Key Household Practices (KHHP)
- ref to KAP on ACSD behaviours
- ref to meetings to devt action
- ref to IMNCHcom finalization workshop
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IMNCH SITUATION ANALYSIS

Maternal Health

Maternal health is closely linked to child health. The quality of life of mothers usually has implications for the quality of life of their children, especially children under the age of five. Studies have also shown that a mother's level of education affects health seeking behaviour for herself and her child and determines extent of practice of key household behaviours (NDHS, 2008).

Maternal mortality rate in Nigeria is estimated to be 800/100,000 live births (FMOH, 2007 and 2009) with some other estimates ranging from 704 -1500/100,000 live births. The latter is higher than the sub-Saharan Africa average of 910/100,000 (WHO). However, a wide variation exists across the geopolitical zones. The North East Zone has the highest maternal mortality rate of 1,549/100,000 live births compared to 165/100,000 live births for the South West Zone, an almost 10 fold difference. Main causes of maternal mortality in Nigeria are identified as follows: haemorrhage (23%), infection (17%), unsafe abortion (11%), obstructed labour (11%), and toxemia/ eclampsia /hypertension (11%). Malaria (11%), anaemia (11%) and others including HIV/AIDS contribute to about 5% of maternal deaths. It is also estimated that for every maternal death, at least thirty women suffer short to long term disabilities such as vesico -vaginal fistula (VVF). Nigeria accounts for 40% of the global burden of Vesico-Vaginal fistula. This translates to an estimated 800,000 women suffering from the condition arising from prolonged labour and complicated deliveries.

Key determinants of the quality of health of mothers pre and post-partum include Ante-natal clinic attendance, delivery in a health facility and delivery by a skilled birth attendant. NDHS Preliminary Report (2008) states that 58% of women received ante-natal care from a trained health professional at least once during their pregnancy (87% in the South West and South

East, 31% in the North West). Only thirty-one percent of mothers with no education received ANC services from a health professional, compared with 97% of mothers with more than a secondary education. Thirty-nine percent were delivered by trained health professionals and only 36% had their babies in a health facility

Newborn Health

The survival of newborns depends largely on the knowledge and practice of key household behaviours of parents and caregivers. Most newborn deaths in Nigeria occur within the first week of life, reflecting the intimate link of newborn survival to the quality of maternal care. This is reflected in the results of the survey of 289 neonatal deaths by DHS in Nigeria in 2003

- 17% occurred on day 0;
- 44% on days 0 and 1; and
- 74% during the first week of life

According to NDHS 2008, Neonatal mortality rate is 40/1000 while Infant mortality rate is 75/1000 (MICS 2007 reported 91/1000). Most neonatal deaths occur at home, making record-keeping a huge challenge. NDHS 2003 showed that the highest neonatal rates are observed in the North-east and North-west regions of the country while the lowest rates are seen in the South-east region (34 per 1,000 live births). Nigeria ranks highest in Africa in terms of neonatal deaths and the third highest worldwide, contributing about 8% of the world's annual neonatal deaths (ACCESS, 2009)

Child Health

The survival of under-5 year old children, like that of newborn children, depends largely on the knowledge and practice of key household behaviours of parents and caregivers. There has been some improvement in the mortality rates of under-five children in Nigeria over the last six years, though emerging figures are still among the worst globally. Under-five mortality rate is 157/1000 (NDHS, 2008). In 2003, it was 201/1000 (NDHS, 2003).

Easily preventable and/or treatable infectious diseases such as malaria (24%), pneumonia (20%), diarrhoea (16%), measles (6%) and HIV/AIDS (5%) accounted for 71% of the more than 1 million under-five deaths (estimated in Nigeria in 2004). Yet, current data do not show a significant change in behaviours and practices that promote child health. According to NDHS (2008), 7% of Under-five children sleep under an Insecticide-Treated net (only 5% of pregnant women use ITNs too), only 23% of children are fully immunized (29% receive no immunisation at all), only 13% of babies are exclusively breastfed for the first six months of life, 41% of children are stunted, 14% of children are wasted and 23% are underweight. Seventeen percent of mothers have no faith in immunization while 11% complain of distance to immunization post, in spite of frequent Immunisation-plus Days (ACSD KAP, 2008).

Most mothers do not continue to give babies food and fluids during bouts of diarrhoea and only 32% visit a health facility or see a health care provider (MICS, 2007 and NDHS, 2008). Only 24% of mothers knew the danger signs of pneumonia, only 49% of Nigerians had improved sources of drinking water, and 28% had no excreta disposal facilities (not even a field or bush) (MICS, 2007)

ACCESS TO HEALTH

Access in its various dimensions, is a critical determinant of maternal mortality. These dimensions include physical access (distance of 5 kilometres to Primary Health Care services or one Emergency Obstetric Care centre per population of 500,000), cost, cultural factors, access to appropriate information etc.

Financial access: Poverty has significant implications for health and development and poor people generally have poorer health status. Poorer women experience higher morbidity and mortality compared to those of higher socio-economic status. The incidence of poverty is higher in the rural areas, where maternal mortality rate is also higher. The NDHS (2008) results show a great gap in access to and use of health services between rural dwellers and urban dwellers. Specifically, for example, 85% of urban-dwelling women are likely to attend ANC compared to 46% rural-dwelling women. Similarly, children in urban areas are more than twice as likely as rural children to be fully vaccinated; 38 percent compared with 16 percent, respectively (NDHS, 2008). Females are more likely to experience poverty compared to males, as they have lower economic activity rate as well as lower social status. Studies have further shown that, in the face of high poverty level in Nigeria (52.6%), increasing health care cost resulted in substantial decrease in the utilization of maternal health services. Lack of money was one of the most frequently given reasons for not accessing health care services (NDHS, 2003).

Physical access: Distance to a health facility is the second most important reason for not accessing health care services in Nigeria (NDHS, 2003). Access to emergency obstetrics services has been shown to be clearly linked with maternal mortality situation; approximately 15 % of pregnant women may develop life threatening conditions that would need such services for effective intervention. The availability and accessibility of EMOC services, thus, deserve particular focus in the review of the status of maternal mortality.

Access to information: Traditionally, the mass media have been used to transmit health-related information to the larger population, usually without a clear analysis of access, use and effects of the mass media. Unfortunately too, national policies and systems have given prominence to mass-mediated information systems above other traditional, more accessible, acceptable, credible and affordable channels. Incidentally, while access to the mass media is important for acquiring information and knowledge on maternal health issues, the proportion of women that have no access to any mass media is about two to three times that of men in the rural and urban areas respectively (18.7 % compared to 6.3% in urban areas, and 52.5 % compared to 22.6 % in the rural areas). The fact that more than half of women do not have access to any mass media is likely to affect their knowledge and use of health facilities in pregnancy and delivery, and consequently maternal morbidity and mortality occurrence (IMNCH Document, 2007; ACSD KAP, 2008). In addition, it is important to note that other channels of communication including interpersonal communication are critical in engaging with communities on key health and development issues. Women are largely missing out in community dialogue sessions; meetings of community structures (eg, Community Development Committees) and even discussion in peer group meetings; they often receive little or no acknowledgement and forms very little or no part of the decision-taking process. Yet, they are core to ensuring that child survival measures and strategies succeed and their welfare is usually a determinant of the degree to which their children will thrive.

Socio-cultural factors: A number of socio-cultural beliefs and practices in Nigeria limit the ability of women to take autonomous decisions about their own lives, including decision to seek appropriate health care. The decision-making power often lies with the husband or their male relatives, and studies have shown that many women have lost their lives in pregnancy-related conditions while awaiting decision to be taken by such gatekeepers (SITAN, 2007). Women are subject to a lot of myths and beliefs that hinder participation in decision-taking as well as optimisation of their welfare and that of their children (ACSD KAP, 2008). Gender-disparity exists in almost every sphere of life in Nigeria, to the disadvantage of women. Nigeria is currently rated 124th out of 144 countries on the gender-related development index. Prominent areas of gender disparity include education, access to productive resources and social status,

and all these have implications for Reproductive Health status and maternal health. Educational status is highly associated with health-seeking behaviour in pregnancy and delivery, and maternal mortality level is much higher in women with no education compared to women with secondary level or higher education (IMNCH Strategy Document, 2007; See also NDHS, 2008 and SOWC, 2009). Socio-cultural issues are clearly discernible in the major focus areas of the IMNCH behaviour and social change communication strategy focus areas, as discussed below:

Ante-natal Care

NDHS (2008) reports that 58% of women attended ANC at least once during their pregnancy. However, delivery in a health facility is low. About 89% of childbirths in the North West and 82% in the North East take place at home (ACCESS, 2009). Many pregnant women believe that health workers do not provide client-friendly services when compared to Traditional Birth Attendants (TBAs) (PMTCT Formative Research, 2001; PMTCT Evaluation, 2005; IMNCH Document, 2007). TBAs are believed to possess the experience, human feelings, skills and spiritual knowledge and composure to take deliveries under any circumstance and they have a long history of practice behind them, with skills passed from one generation of practitioners to another

Immunisation

Several socio-cultural challenges still hinder progress in full immunisation of children in Nigeria. In some parts of the country, Polio is not linked with lack of immunisation. Rather, it is said to be a result of witchcraft attack while some regard the vaccine as a family planning device which conflicts with religious teachings. More seriously, it is linked to infertility/impotence (ACSD KAP, 2008).

Infant Care

Many traditional beliefs and norms inhibit the practice of appropriate behaviours. Many cultures do not approve of mothers giving colostrum to their babies, saying that it is 'dirty' and can cause stomach upset. More importantly, the major challenge against exclusive breastfeeding is the belief that no baby can survive without water. This belief is even more strongly held in the northern part of Nigeria where temperatures are usually very high (ACSD KAP, 2008, IMNCH Document, 2007). NDHS (2008) also reports that 35% of infants 0-5 months are given complimentary food. There are also anecdotal reports that some mothers prefer to give breast-milk substitutes, especially tinned infant formula, as an expression of status, because it is expensive to sustain, in view of the high cost of tinned infant formula.

Oral Rehydration Therapy, as an antidote to diarrhoeal diseases, carries with it some cultural coloration. According to MICS (2007) only 17% of mothers continue to feed and give water to babies during episodes of diarrhoea. The general belief is that continued food and fluid intake exacerbates the diarrhoea. Many parents and care-givers prepare several kinds of drinks using local herbs that are believed to possess therapeutic effects.

Malnutrition is a major challenge in most parts of Nigeria. Available data show that 14% of children are wasted, 41% are stunted and 23% are underweight (NDHS, 2008). Yet, some cultures do not encourage giving children nutritious foods like eggs, beef and fish. It is believed that children who are given nutritious foods end up as criminals.

Handwashing

Cultural practices relating to handwashing may be gradually responding to aggressive information on the benefits of the practice. Baby stool used to be regarded as harmless and

there was no need to wash hands after cleaning a baby (SITAN, 2007) but current data show that there is increasing acceptance that it is equally harmful (KAP, 2008). Many parents do not encourage their children to wash hands, regarding handwashing as adult behaviour. Sometimes, handwashing is done in a common bowl, using available water, thereby recycling possible sources of infection.

Use of Insecticide Treated nets

Only 7% of under-5 children sleep under ITNs and only 5% of pregnant women sleep under an ITN. The low figures reflect some socio-cultural impediments to using the ITN, including perception that it emits an offensive odour which is regarded as potentially dangerous to humans. ITNs are also believed to be cumbersome to use, especially the nightly draping (ACSD KAP, 2008). Anecdotal evidence also indicates that in some cultures, it is used for preserving corpses from flies before burial.

HIV and AIDS

Risk perception about HIV and AIDS is low among all classes of Nigerians. There is a general belief that the virus is a creation of the Western world and does not possess the deadly features it is said to possess. HIV positive persons are sometimes regarded as under the attack or influence of negative spiritual forces and are not welcome to live in some communities. There is also an overwhelming belief that anybody that is HIV positive was infected through heterosexual sex, thereby stigmatising infected persons, including children (HIV/AIDS BCC Strategy 2004)

Multi-media Landscape: In spite of some barriers to reach the mass media owing to economic and literacy factors, they remain the channel with the highest reach. Radio usage is higher compared to access to television and newspapers. The print media are a key information channel for opinion leaders and policy makers. However, radio has been used extensively to reach groups in communities with special programmes promoting the rights of children. The mass media have been contributors to massive awareness campaign activities and provide opinion leaders and, sometimes household heads, with information and knowledge on appropriate practices which trickle down to individuals within the family and facilitate the adoption of positive behaviours.

Key examples of effective media use, include the series of radio jingles by NAFDAC against the illegal sale and use of Vitamin A; the intensive information campaign following the onset of Avian Influenza in Nigeria; the on-going HIV and AIDS campaigns in almost all national and FM radio stations and the local dialect broadcasting over a quarter by radio stations in Enugu on several harmful traditional practices. The careful documentation of these jingles and Public Service Announcements (PSAs) can be improved on. The growth of interactive radio broadcasting is encouraging the strengthening of message content clarification through its feedback process. Emerging opportunities exist in the increase in Nigeria's GSM teledensity as its usage is widespread both in urban and rural areas and text messages have been used to reach millions of people during information campaigns. The number of GSM lines in Nigeria increased from zero in 2001 to nearly 19 million in 2006. A major challenge in this is still the limited access to telephones by rural communities.

Lessons from Previous C4D Programmes: *Community Dialogue* is the most popular strategic approach used and was prompted in part by the polio controversy which necessitated dialogue with religious and traditional leaders, civil society groups and media associations. This approach has also been used in other projects such as Girl's Education, Sanitation and Hygiene promotion, HIV/AIDS and Avian Influenza. An independent Community Dialogue Audit was sponsored by UNICEF in six States (Kano, Kaduna, Katsina, Jigawa, Bauchi and Zamfara) from

June to September 2007. The audit showed that there was a 60% reduction in non-compliance for polio vaccination in 64 communities between the 3-month period of June to September. The dialogues have increased participation and self-determination among families and communities. Furthermore they have resulted in the availability of a pool of community resource persons who facilitate these sessions of dialogue and who now have the required knowledge and skills.

Community Theatre for Development (TfD) has been another indigenous interpersonal approach that has enjoyed much acceptance, acclaim and has been a useful tool in stimulating discussion in communities on issues of child survival and development (Ibadan/UNICEF TFD Manual, 2005). The involvement of community members in the planning, implementation and evaluation of this process, as in other processes, has made it an exciting and cheap way of mimicking current attitudes and practices and in presenting models of behaviours and practices to promote and also address common barriers to ideal behaviours. It has been an invaluable approach in addressing immunisation, breastfeeding, hygiene and sanitation (Osofisan, 2003)

Community viewing and listening centres have been a part of the messaging processes in communities. While the listening centres are in more locations than the viewing centres, enhancing youth participation, life skills acquisition, discussion and the provision of correct and complete information, group listening and viewing is a common feature in most communities. A major challenge has been the regular availability of electricity for viewing, costs of operating generators, updating the messages viewed or listened to and poor maintenance of the facilities (UNICEF Annual Report, 2005). They however continue to be a strategic inclusion in the approaches for reaching communities, especially young people.

The Community Information Board (CIB) is a tool for social data gathering, a key element in sustainable dialogue and action in communities. Given the importance attached to social development initiatives by various levels of Government and development partners, the need to support communities to make informed decisions pertaining to the situation of children and women within that domain is critical to scoring progress.

The Community Information Board (CIB) is used by communities to:

- Provide basic and readily available data
- Plan and monitor progress on or defaults in the implementation of development activities at the community level
- Generate topics for dialogue at health facility level, during peer and community dialogue sessions and materials for local theatre scripts
- Promote dialogue on development issues at the community level
- Enable communities monitor and correct negative practices as well as sustain positive behaviours.
- Motivate traditional and religious leaders / Community Development Associations/Committees (CDA/Cs) to generate issues for discussion and action.
- Galvanize the community into action

A 2009 Rapid Assessment of the use of CIB in 16 states of Nigeria showed a good adaptation of the tool and the promise of widespread use across the country if additional capacity is developed, government involvement is sustained and communities own the process

2. The Integrated Maternal, Newborn and Child Health Strategy

2.1 Rationale

The total population of under five year in Nigeria is estimated at 22 million of which an estimated 1.1 million die every year. Similarly, over 53,000 women die in Nigeria every year from pregnancy and delivery related causes. However, medical research indicates that through a combination of well-delivered high impact interventions, appropriate household and community-based care practices the situation can be reversed rather quickly.

The Presidential 7-Point Agenda is the main point of reference for national development efforts in Nigeria and highlights human capital development: education, health and skills as well as cross-cutting issues such as employment, gender and HIV/AIDS as some of the main points of focus. Its implementation is supported by a National Development Plan and a National Economic Empowerment Development Strategy (NEEDS) for poverty reduction and development.

In 2007, the Federal Ministry of Health launched the Integrated Maternal, Newborn and Child Health (IMNCH) Strategy that has been endorsed at the National Council on Health as well as all partners. It is envisioned that this framework will serve as the vehicle to scale up key maternal, newborn and child survival interventions at community level with a package of core high impact interventions and household practices whilst simultaneously revitalizing the weak Primary Health Care systems.

2.2 Goal

To empower families and communities with the information, skills and tools they need to make critical informed choices and take action to ensure the health and general wellbeing of mothers, newborns and children under 5 years old

2.3 Objectives

The primary objective is to improve the practice of appropriate maternal, newborn and child care at the household and community levels. Secondary objectives are to ensure that health staff offer factual, credible and friendly health promotion services and that they work in partnership with community volunteers and structures to monitor and support critical behaviour pertaining to maternal and child health.

2.4 Planned Outcome Results

The planned outcome results for the primary participant group (i.e. pregnant women and mothers with under 5 year old children) is regular practice of critical behaviours during pregnancy, post delivery and during growth of child from birth to at least 5 years old.

For the secondary audiences, which include husbands, mothers-in-law, siblings, religious and traditional leaders, peer and community social groups, health workers, TBAs, and community counselors) the planned results is effective counseling and support so that the enabling environment for sustained practice of the key household practices are sustained.

2.5 Strategic risks and Assumptions

The principle risk that would affect the achievement of the result are basically on the availability of supply inputs in time and in quantities that will cause effect and impact. The non timely availability of supplies, or their inadequacy could limit coverage and reduce demand through discouragement by unmet need. In addition, limited participation and low support of key community leaders due to deep seated prejudice on contemporary interventions as already experienced during polio eradication campaigns.

To manage this risk,

- the process of participatory microplanning will ensure that communities participate and share in all responsibility for non availability of adequate supplies when needed.
- Participatory message and material development followed by several rigorous forms of pre-testing of message concepts should minimize potential of risk of non-culturally acceptable messages.
- Constructive engagement with trusted leaders, listening and incorporating their inputs for initiation and sustaining access to quality services can help to build confidence in the programme.

This strategy is based on the assumptions that;

- This will focus on simple no-cost actions that parents can take at the household level which will prevent death and illness of children and can even save their lives.*** These include exclusive breastfeeding, use of home-made oral rehydration solutions when children (and adults) have diarrhoea.
- The services required outside the home will be accessible (physically and financially) to parents as and when required.*** For household behaviours to be sustained they need to be reinforced by the health facilities whenever families make contact either for preventive or curative services. Such health education services will help parents know how to recognize danger signs and when to take women and children to health facilities for care, as well as understand the value of certain practices like immunization.
- At the community level key services (health, nutrition and WASH) will collaborate and coordinate their support to families for a more holistic (physical and social) care of children and families.*** Research clearly informs us that without basic services like clean water or adequate sanitation challenges to appropriate child health and development abound. Hence the need for an integrated and holistic approach to child, maternal and family health that pays equally important attention to the services delivered by other sectors.

2.6 Programme Principles

Four simple core principles will underpin the entire IMNCH behaviour and social change strategy. These include:

- Integration using multiple opportunities

The IMNCH communication interventions will contribute to “learning by doing” delivery in an integrated manner in the context of Family/Household Mode of the IMNCH strategy, combining appropriate behaviour change communication for appropriate health practices. This learning will also be documented. Emphasis will be placed on use of a communication for development strategy that focuses on strong community engagement and use of multiple communication channels for key messages across maternal, newborn and child health to include personal hygiene and environmental health. The health facility based interventions will be linked with community based initiatives and community outreach services with high involvement of community health workers and volunteers. Complementarity and integration will be maintained through the following:

- participatory micro-planning for all the critical components
- facility based interventions for client-friendly services also linked with community outreach and community involvement for household counselling
- Complementary community based initiatives are designed for all the components by the key members and actors in the community in a participatory manner with sensitivity to increased role of women, children and youth.

- ii) Partnerships for harmonization and rapid roll-out
Partnerships will be
 - with counterparts in Government Ministries, departments and Agencies whose capacities will be developed for behaviour and social change strategy development and programming to address challenging social development issues
 - reinforced with media institutions with skills to cover infant maternal and child care issues impartially and accurately in a way that provides 'Facts For Life' information to families and communities.
 - established with NGOs and community based groups who will be provided with audio materials to reinforce information delivery and stimulate discussion with outreach groups.
 -
- iii) Pre-and in-service training of service providers for sustainability of improved practices
- iv) Inclusion, participation and self determination by communities for an enabling environment for behaviour change

2.7 Scope

The plan is that immediately after the launch of this strategy, the implementation of the social marketing component of the strategy will start using national, commercial and **university**-based community radio stations. This is to ensure reach to all parts of the country with information and to facilitate interaction over the airwaves (especially through dialect programming). By 2014 the entire country will have been reached by intensive inter-personal community-based strategies in line with the roll-out of the IMNCH strategy. Several capacity development and monitoring components will also be closely linked to the two-part roll-out of the IMNCHcom strategy

2.8 Priority Behaviours

UNICEF's landmark publication, the '**Facts for Life**' carries the basic household, community and facility-based information required to ensure appropriate care during pregnancy, childbirth, and for the first five years of a child's life. This booklet was adapted in Nigeria to simple, local pidgin language and later translated into 3 local languages – Yoruba, Hausa and Igbo. Since then the international version of the **Facts for Life** has undergone at least two updates. The national (Nigerian) versions have not kept pace although

In 1998, WHO and UNICEF identified 12 key family and community actions that support the primary health package of Integrated Management of Childhood Illnesses (IMCI), which were very similar to the original FFL.

In 2000 in Durban, WHO, USAID, World bank, UNICEF and other partners agreed to focus on 4 key priority behaviours. These are exclusive breastfeeding, use of Insecticide-Treated Bednets, handwashing and Oral Rehydration Therapy. On its own, the Government of Nigeria has supported the promotion of Nineteen Household practices since the commencement of Community Integrated Management of Childhood Illnesses (IMCI)

- | Priority Behaviours to Promote | |
|--------------------------------|---------------------------------|
| 1. | Antenatal clinic attendance |
| 2. | Exclusive breastfeeding |
| 3. | Handwashing at 4 critical times |
| 4. | ORS (and zinc) use |
| 5. | ITN use |
| 6. | Routine Immunisation |
| 7. | Growth monitoring |
| 8. | HIV/AIDS prevention |

At the IMNCH communication strategy finalization workshop in Jos in July, 2009 it was

agreed that while recognizing the importance of all 19 key household practices, in line with good practices from other countries, there shall be greater focus on eight (8) select priority behaviours. All 19 KHHPs are addressed in the activity matrixes and action plans. The selected behaviours have the potential to dramatically reduce morbidity and mortality if effectively implemented.

Maternal Health

1. Marry after age 18 years and delay 1st pregnancy until after marriage
2. Register pregnancy during the 1st trimester i.e. by your 12th week
3. Have a check by a skilled health worker at least 4 times during each pregnancy to include abdominal examination, tetanus toxoid injections, iron-folate and malaria prevention tablets
4. Eat enough good foods, rest more and do not carry heavy loads
5. Share housework (especially collection of water and firewood) with husband and other family members
6. Know how to recognize complications during pregnancy and seek appropriate referral
7. Deliver at a clinic or hospital that has a skilled health worker trained to handle any complications and can ensure a safe delivery
8. Make (financial and logistic) preparations to get you to the nearest clinic when labour pains start

Newborn Health

1. Keep newborn warm
2. Initiate exclusive breastfeeding within half hour after birth and give the colostrum to the baby for some immunity against disease
3. Provide only breastmilk up to 6 months. It has all the water and nutrients a baby needs even in hot dry climates
4. Do not give water, glucose, honey, pap or other foods for the first 6 months after birth (except medication prescribed by a doctor)
5. Wash hands with soap before caring for new-borns to reduce the risk of infection
6. Make sure the baby starts routine immunization with the first doses of BCG and OPV shortly after birth
7. Give responsive and equal care to the baby boy and baby girl
8. Register the birth of the child within 1 month

Child Health

1. After 6 months, provide adequate complementary feeding, and continue to breastfeed up to 2 years.
2. Give other foods like thick pap, after breastfeeding, at least 5 or more times a day
3. Wash hands with soap before preparing a meal, feeding the baby, after changing the baby, and after using the toilet
4. Seek services and counseling for complete routine immunization, Vitamin A supplementation
5. Go to a health facility to monitor the growth and development of the child
6. Use only drinking water from a protected source. Keep this water safe during transport, storage and use
7. Manage diarrhoea (with continued feeding and oral rehydration therapy),
8. Manage malaria, fever, pneumonia and respiratory infections by learning standard household care practices.

9. Dispose of a child's faeces safely and encourage all children and adults to use the toilet daily
10. Use only iodized salt to prepare food for children and all family members.
11. Store food safely and heat before serving to children and other family members
12. Encourage fathers to practice parenting skills (e.g. ensuring immunization and care; playing, communicating with and caring for the young child).

Chapter 3 Strategic Interventions

3.1a. Health Information Boards

An analysis of campaigns indicates that intensified activities suddenly end once the funding is exhausted and targets are met. As in the case of the Universal Coverage on Immunization, (UCI), the targets quickly eroded after the campaign ended and the key issues were no longer in the society's eye. The key lesson here is that for ongoing engagement of communities in dialoguing on issues pertaining to the wellbeing of children and families, the issue has to be constantly kept in the public eye and general community agenda.

The Community Health Information Board (CIB) is a tool for the gathering of social data, a key element for sustainable dialogue and action in communities. The Community Health Information Board is used by communities to:

- Provide basic and readily available data
- Plan and monitor progress on or defaults in the implementation of development activities at the community level
- Generate topics for dialogue at health facility level, during peer and community dialogue sessions and materials for local theatre scripts
- Promote dialogue on development issues at the community level
- Enable communities monitor and correct negative practices as well as sustain positive behaviours.
- Motivate traditional and religious leaders / Community Development Associations/Committees (CDA/Cs) to generate issues for discussion and action.
- Galvanize the community into action



The principal moderator of the Board is the Traditional leader and the Community/Village Development Committee (C/VDC). The audiences, therefore, include the entire community -

women, youths, children and men. Participation of all segments of audiences is guaranteed in the dialogue sessions where issues that arise from the Board are discussed, action plans developed and commitments to act made and tracked. The Board shows progress of the community on various child/maternal survival, development, protection and participation indices and various segments of the community have a chance to participate in responding to issues that arise from a common analysis of the implications of information on the Board for progress in the community

3.1b Community Dialogues

Communication interventions will facilitate and support dialogues at the community level so that the added value of new practices, opportunities and obstacles to adopt them as well as ways to overcome obstacles can be agreed collectively and the impact on both social norms and individual behavior ironed out and embraced by all.

The strategy involves identifying the more vulnerable high risk communities, briefing the Mai Angwa (traditional leader) who is expected to chair and facilitate the dialogue, and ensuring that women, religious leaders and local organizations are represented. Each dialogue starts with prayers to set the moral standard of the meeting, followed by introduction of the purpose of the meeting and the basic facts concerning the issue (i.e. the disease burden) at hand. During the dialogue, local service providers, equipped with IEC materials, will support factual response to questions and also create space for community advocates to respond to some of the concerns raised as it is easier for community members to make the link to local norms and proverbs that compliment proposed behaviours. Then participants are asked to suggest ways of working together to address the identified (issues(s). Where an affected person (either a polio victim or HIV infected person) is around he/she is given the opportunity to talk about his life's challenges as a means of convincing laggards. The group will then agree on the key action steps, including who is to do what, for action to be implemented. The Health team supports the community in developing plans and identifying resources to implement suggestions e.g. drama. Before dispersing, everyone is reminded of the decisions taken and the dates for any upcoming health facility event - routine immunization days at the local health Centre. Reminders also include dates for pre-natal clinic days, or date for a revisit by the outreach team.

Community Dialogues have the added advantage of tapping a cascade of institutionalized traditional interpersonal networks that carry enhanced credibility and reach households and communities. An audit of the community dialogue approach conducted in September 2007 underscored the value of the approach in contributing to achievement of programme results. The assessment revealed that there was 16% increase in the number of children immunized in 89 communities with monitored dialogues and a 60% reduction in the number of non-compliant households in 54 communities with monitored dialogues in the most high risk states. Within a year of its introduction, all programmes to which programme communication was providing cross-cutting support were using community dialogues as the primary approach to increase social learning, participation and ownership as well as to initiate steps towards more equity in information sharing and participation in communities.

Research has proven that the most successful and sustainable approaches in the field of behavior change are based on the active participation of all stakeholders - so that beneficiaries freely choose to change individual behavior and collective practices, rather than being told to change or have change imposed upon them by 'external' technical specialists.

3.1c Social marketing with the Mass Media

Radio is accepted globally as having the highest, most cost-effective reach and penetration, especially to remote rural areas in Africa. In Nigeria at least xx% of the population is reached by radio an estimated xx% by television. Priority attention will be the social marketing key products and services will be used to socially market the critical practices and associated services over the airwaves, especially in the local languages. These include (i) Formative research – among participant audiences to identify current mindsets, knowledge levels, household and community practices. This will facilitate the development of key messages and appropriate media plans for national, state and local levels and (ii) mass media activities (radio and TV and mobile cinema) including print materials on the various themes. These would be distributed through multi-media channels. This segment will include motivational methodologies – competition, awards as appropriate.

The mass media will be used for 'agenda setting' to ensure that IMNCH issues and concerns remain visible on the national agenda.

Work with television is not expected to be as extensive as that with radio due to the high costs involved. In this regard priority will be given to health and family programmes and comprehensive news reports.

Mobile information vans are available within the National Orientation Agency and the Federal Ministry of information and will be more efficiently exploited to reach remote areas with information and to stimulate dialogues to ensure the issues pertaining to local community contexts are addressed.

Mobile cinema was extensively used in Nigeria during colonial times to engage communities for preventive health.

3.1d Working with celebrities (Sports, TV, Music)

The project will involve national celebrities in activities that will allow them to interact with and engage youth for specific practices especially for HIV/AIDS prevention. Lessons will be drawn from the south African 'Sports for Development' experience.

Chapter 4 – Partnership

The primary partnership proposed is that between the health facility, community-based organisations and community structures so that there would be a common understanding of the common maternal, newborn and child health problems/challenges in the community and the required actions to be taken at the household, community and facility levels to address them. Also agreement on what is required so that proper advocacy can be made by the community leaders whether for supplies, human and financial resources or even training of staff to ensure efficient delivery of services.

The Partnership for the IMNCH strategy has provided a platform to consolidate partnership support at country level. Major partners subscribing to the roll out of the strategy include:

- USAID ACCESS and other projects: Maternal and Child Health Projects , Malaria Program support
- Save The Children: Maternal and Child Health Projects and neonatal health plan of action; Nutrition programs.
- World Bank: Support to the Malaria Booster Project and the Health Systems for development Project.

- WHO : Technical support
- GAVI : Immunization Support Services
- DFID : Maternal and Child Health Projects and Health Systems
- Gates Foundation : Innovation approaches in Neonatal Health
- United Nations Population Fund: Reproductive Health with particular focus to Obstetric Fistula management, Emergency Obstetric Care and family planning

It is expected that these same partners will also have representatives on the Advocacy, partnership and fundraising Committee.

The implementation of the IMNCH Behaviour and Social Change Communication Strategy requires the building of alliances and partnerships that involve a wide range of interests and stakeholding. The scope and intensity of the IMNCH programme was arrived at with the understanding that diverse partners will feed into the various stages of work and share responsibilities in line with mandates and work focus. Partnership cuts across all tiers and levels of governments and particularly integrates the inputs of communities, health service providers, children and young people, institutions at all levels and different interest groups that jointly focus on realizing the health goals of children and women.

The guiding principles of the partnership framework as elaborated in the IMNCH strategy include the necessity for leadership by the Federal Government and State Governments, as appropriate. Other key elements of the framework are Inclusiveness, Collaboration, Comprehensiveness and Drive for Results (MDG 4 and 5 and overall Human Development). The partnership is expected to promote maternal, newborn and child health issues at all levels of government, work at expanding linkages with other local and global partners and support the overall programming process. This is even more critical for behaviour and social change that rests on supporting a rapid scale-up of high impact interventions linked to promoting child survival and maternal health

The behaviour and social change partners represent various clusters and professional categories and come with a variety of skills and experience. They also operate within defined contexts, from national to state, Local Government Areas (LGA), Districts, Wards and Communities. The overall leadership rests with Government at all levels, represented by the Federal/State Ministry of Health and the LGA Primary Health Care Unit. Component members include academic institutions, professional organisations, faith-based organisations, the private sector, children and youths and civil society groups.

Academia: Academic institutions possess a wealth of resources that can ensure continuous access to technical guidance in programming. Universities and other training and research institutions will continue to provide capacity development services (training, development of tools, job aids and other resource materials) on various aspects of communication for behaviour and social change to various categories of programme managers and service providers. They will also anchor the Monitoring and Evaluation component of communication support to IMNCH.

Faith-Based Organisations: Faith-based groups in Nigeria are an intrinsic part of health programming. Religious leaders are critical gatekeepers and have a great degree of influence over their followers. More importantly, many religious groups have organized programme response to emerging health issues, especially Malaria, HIV/AIDS, Sickle Cell Anaemia and Tuberculosis. They also have Ante-natal care and maternity services. These are usually run by serving or retired health workers. They are important in behaviour development and change processes and do play catalytic roles in social change. Examples of religious groups that have

been active in partnerships for health include the Catholic Church, Federation of Muslim Women's Associations of Nigeria (FOMWAN), The Anglican Church, and the Redeemed Christian Church of God.

Professional Organisations: Several professional groups are active in promoting health and health-seeking behaviour. These groups have the technical expertise, skills and credibility to contribute the process of social transformations. They are in the frontline of service delivery and have direct contact with those who seek services, including counselling and information. They would play a major role in creating demand for ante-natal services, delivery in health facilities, immunisation, and lead the process in providing guidance to clients on adherence to Key Household Practices, including exclusive breastfeeding, handwashing and sleeping under insecticide-treated bednets. The organisations include the Nigerian Medical Association, the National Association of Nigerian Nurses and Midwives and the Pharmaceutical Society of Nigeria.

Private Sector: The private sector have been an active part of health programmes in the last few decades. They have been active in promoting health, nutrition, handwashing, immunisation, HIV prevention as well as supporting service delivery, capacity development and research through funding of specific projects (including campaigns) and donation of materials. The private sector would provide funding support for capacity development, monitoring and evaluation and periodic social marketing campaigns, among others.

Children and Youths: A major guiding principle of the partnership for behaviour and social change for IMNCH is inclusiveness. The exclusion of children and youths in communication for development programming has been found to be a major gap in strategy that has denied programmes the added value of the innovation, energy, zeal and insight that children and young people have to offer. Young people and children are critical in the social mobilisation and behaviour development/change process. They have influence on their peers and they offer parents and community members information to remind of and reinforce KHHPs while acting to guard against negative practices. Several programme areas have documented the effectiveness of including children and youths in programming partnerships structures. They include the Polio Eradication Initiative (Child Adoption), Basic Education (Child-to-Child), HIV and AIDS (Peer Education, both for the NYSC Project and the Family Life and HIV Education project).

Civil Society Groups: Civil Society Organisations (CSOs) are a natural partner in communication for development related to maternal and child health. They have, over the years, championed the review of structures for service delivery, advocated for more funds, supported service delivery, including championing client rights to friendly health services, championed community inclusion and engagement and supported capacity development at various levels. CSOs have also been part of processes to generate evidence that have guided programming. They have been on the frontline of advocacy with governments and parliaments on building health systems and better funding for the health sector.

Some key benefits of effective partnerships include harmony and synergy in programming, avoidance of wastage through duplication of effort, maximizing inputs by focusing on a common goals and targets, joint work-planning and programming, reviews, monitoring and common indicators for measuring change. Some of the benefits of partnership is attaining common goals, sharing common success stories and jointly revising strategies when this needs to be done to achieve greater efficiency and effectiveness in programming.

Chapter 4 – Management and Coordination

The success of any strategy is largely hinged on the management and coordination structures and systems. The IMNCH Behaviour and Social Change Communication Strategy complements the existing IMNCH Strategy in terms of meeting the defined targets for achieving MDGs 4 and 5. Its inputs are, however, related to defined communication and behavioural objectives that contribute to meeting the strategic result defined for IMNCH in Nigeria.

Management and coordination of the IMNCH programme is led by the Federal Ministry of Health, in consultation with the various State Ministries of Health. The communication component be coordinated within the same structure but with broader participation and clearer terms of reference for the substructures that are created to support communication for behaviour and social change.

The structure below shows an Inter-Agency Coordinating Committee at the apex of affairs. It is important to note that this structure was set up to drive the Polio Eradication programme of the Government of Nigeria and has been working to support other health programmes in recent times. However, the structure does not capture the crucial role of the National Council on Health, in view of the concurrence of health programming in all tiers of government. It also focuses on sub-structures that do not complement the current communication strategy to support IMNCH, specifically the communication for development drive and focus of the support.

Structure of MNCH Partnership for

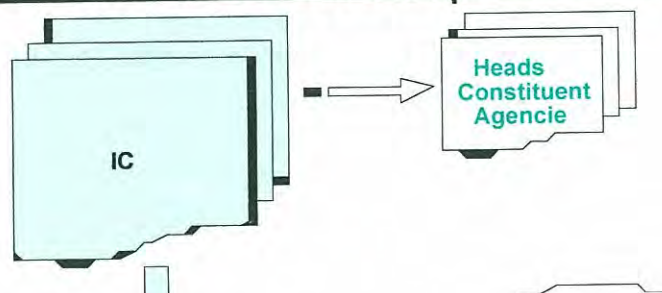
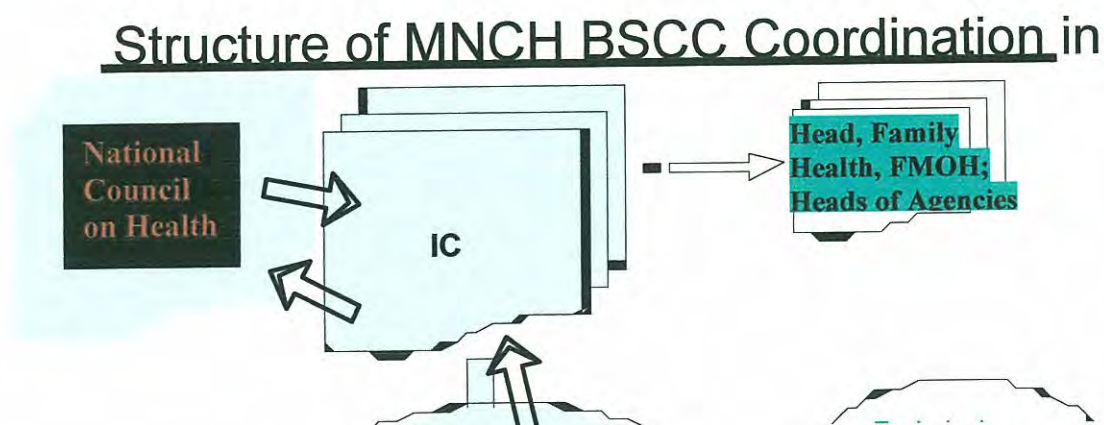


FIGURE 1: STRUCTURE FOR MNCH

The key structures for behaviour and social change are the Core Technical Committee and the Advocacy, Communication and Resource Mobilisation Working Group. While the Core Technical Committee comprises several working groups, the Advocacy, Communication and Resource Mobilisation Working Group will be broken into two to separate functions and allow for dedicated pursuit of clear and operable terms of reference. The adjusted structure below captures the clear focus of the Communication for Development Working Group on Behaviour and Social Change Communication issues that relate to MNCH.



representation from all agencies in the IMNCH behaviour and social change communication partnership. It shall create a forum for discussing issues that emanate from the Communication for Development Working Group as well as issues that have implication for behaviour and social change programming nationwide.

Communication for Development Working Group: This working group shall be chaired by an agency nominated by the Director, Family Health Division and its membership shall comprise all partners working on communication related to IMNCH. The chairmanship could also be alternated on an annual basis by Un and development partners. Its terms of reference shall be to facilitate implementation of the IMNCH BSCC Strategy, including providing technical and logistic support to states and LGAs in the implementation process. It shall bear the standards in ensuring that all partners adopt the Strategy document as the framework for operation and a basis for support to government at all levels. It shall also discuss, adopt and implement an operational plan

FIGURE 2: REVISED STRUCTURE FOR IMNCH BSCC

National Coordinating System

Coordination and management of the National Behaviour and Social Change Communication Strategy for Maternal, Neonatal and Child Health shall rest on the Honourable Minister of Health, who also chairs the National Council on Health (NCH) and the Inter-Agency Coordinating Committee (ICC).

National Council on Health and the Inter-Agency Coordinating Committee: The national communication structure shall be represented at the NCH and ICC by the Director, Family Health Department of the Federal Ministry of Health and Heads of Agencies that have a strong Communication for Development mandate. The Director