Some Recommendations for
IEC at RACHA
1999-2000 and Beyond

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July 1999
INTRODUCTION

This strategy was developed as part of a consultancy from March to July 1999 to strengthen the IEC component of RACHA. The strategy development process involved a number of activities, including:

? a review of the IEC environment
? a review of RACHA’s programs and an IEC needs assessment, through interviews with program staff and field visits
? a comparison of activities being implemented by other agencies working in reproductive and child health, to determine opportunities and priorities
? an assessment of IEC capacity within RACHA
? a presentation and discussion of the potential of IEC, important concepts, and RACHA’s opportunities (See Appendix A)

RACHA is undergoing a redesign process to develop a more coherent vision and mission. At the time of this consultancy, the process had not yet been completed. As strategy should proceed from the vision, the timing was not ideal. Nonetheless, there are a number of recommended next steps, activities, as well as approaches, to strengthen the IEC component. For the longer term, three levels of strategies are offered as alternatives, depending the level of funding that is available in the future.

The IEC Environment

In the current environment, IEC staff struggle to keep up in a functional, support role to service delivery activities. Having IEC play a more strategic role remains a key challenge.

There are five main obstacles:

? a great number of interventions being funded and implemented simultaneously
? relatively low IEC capacity in both the public and private sector
? insufficient funds allocated for IEC
? ineffective coordination and utilization of existing materials
? emphasis on improving the supply side over the demand side in both curative and preventive health care.

The first two factors result in the low absorptive capacity frequently describing the supply of services, especially in the public sector. However, with IEC/BC communication, the private sector has room to grow. A number advertising agencies and commercial art firms are already established in Phnom Penh, albeit with a strong expatriate presence. This capacity remains virtually untapped.

In the arena of reproductive and child health, there are already a number of organizations developing and producing materials. This is in response to frequent complaints from health staff of a “lack of IEC materials.” Frequently, the problem is less one of availability and more one of effective distribution. It is difficult for organizations to determine the availability of such materials, or to attempt to
coordinate with other organizations. Their materials and messages end up competing and confusing, instead of complementing and reinforcing.

**National IEC Strategy.** To address these issues, the National Reproductive Health Program recently developed a multisectoral National IEC Strategy for Reproductive Health. RACHA's strategy should be consistent with and supporting of this National Strategy. Furthermore, there exists an opportunity for RACHA to support the National MCH Center in operationalizing and implementing its IEC strategy.

### IEC Needs Assessment

By reviewing RACHA’s various project components by budgeted activity and with responsible team members, a number of IEC needs were discussed (see Appendix B). For example, RACHA’s support to sterilization services was yielding little impact because few clients were seeking services. Thus the service availability required promotion, and the demand for the services needed to be generated.

Specific project components – sterilization, community development and health promotion, and SIS staff – expressed the strongest ongoing need for IEC assistance. However, situational needs that arise tend to go unmet, as the capacity is not there to respond. Further, some components were not fully aware of how communications assistance could benefit their particular activities. For example, support to the Cambodian Midwives Association could be augmented by a communications plan for the CMA to improve member services.

IEC capacity within RACHA is limited, in that no full-time expatriate position exists for IEC, and until recently no staff worked full-time in the area of IEC. This has recently improved with the dedication of two junior staff members to an IEC unit. These individuals are trained in medicine, and thus will require substantial training in communication and development as IEC/behavior change technical specialists.

Prioritizing among the needs is quite difficult at this time, as RACHA itself has yet to determine its own programmatic direction, the environment is rapidly changing, and all the identified needs are not necessarily priorities for involved stakeholders. For example, IEC for birth spacing had been covered by the UNPFA/MSI National Reproductive Health Program, and there seemed little need for RACHA to put resources in that area. Unfortunately, recent budget cuts from UNFPA indicate that that project may not be able to implement planned IEC activities, thus creating a new need for IEC inputs.

RACHA will best be able to meet its own programmatic needs for IEC support by strengthening collaboration at the national level with other organizations. UNFPA/MSI, UNICEF, Partners for Development, Ministry of Women’s Affairs, PSI, RHAC, and PATH are current and potential partners.

**Community-based materials.** At this time, only a small percentage of the population currently interacts with the public health system, and alternative approaches to service delivery (such as integrated community development or
community-based distribution) may be effective, supplemental approaches to improving the health of the population in the short term. Because most IEC materials are provider-oriented and currently designed for use at the health center, there remains a need for creative efforts to develop appealing, credible messages and materials for the community level.

**Clinic-based materials.** At the health center level, a number of organizations, including UNICEF, have proposed the idea of developing a basic package of IEC materials, to support the Minimum Package of Activities. To meet its own needs for clinic-based materials, RACHA can participate in the development of this package.

**Increasing demand for and access to services.** The new results framework being developed for RACHA includes IR2, Increasing Demand for Services, and IR3, “Increasing Access to Services.” Effective communication is essential to all three IRs, but IR2 and IR3 in particular demand strategic communication. In order for RACHA to meet these objectives, RACHA needs to develop internal IEC capacity as well as help shape the environment so that strategic communication becomes possible.

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**SHORT-TERM STRATEGIES - THROUGH 2000**

The objectives of the IEC team are to provide IEC support to the Provincial Departments of Health in Siem Reap, Kampot, and Pursat, in the areas of reproductive and child health.

**Materials Development Strategies**

Because of current constraints on institutional capacity, RACHA's IEC objectives must be focused, highly selective, and focused on a support role. To accomplish this, the IEC team will make effective use of existing resources by employing the following coordination strategies:

1. **Focus the majority of effort on a single health topic.** While the team will need to assist the various program areas as needed, they should concentrate their main efforts on developing and implementing a single comprehensive IEC program. Promotion of sterilization was selected for a number of reasons, and a promotional strategy developed.

   Appendix C contains the rationale, strategy, and creative briefs for this program. The strategy is consistent with the National IEC Strategy and fills and important (underdeveloped) niche in the National Reproductive Health Program.

2. **Identify, and acquire, and distribute materials produced by other organizations, and train providers in effective use of these materials.** After identifying a need, the IEC team should investigate the availability of existing materials (produced by other organizations). If a match is found, the team will evaluate the appropriateness of the materials, and then acquire and
distribute these materials. Training health staff in the effective placement and use of these materials will increase their effectiveness.

3. **Collaborate with other organizations to produce materials of mutual benefit.** If a material is not currently available, but is planned or needed by another organization, collaborate with that organization to produce the materials. The IEC team should continue to collaborate with UNFPA/MSI and RHAC, expand collaboration with Ministry of Women’s Affairs, and begin collaboration with PFD.

4. **Participate in national level-initiatives on IEC.** The main opportunity is to create a package of IEC materials to support the MPA. RACHA staff should follow up with UNICEF and if necessary provide leadership in this effort. Other opportunities include further collaboration with UNFPA/MSI on the development and testing of safe motherhood materials.

5. **Contract out the production of materials on a limited basis.** RACHA will still need to occasionally produce new materials or adapt existing ones. This should be considered the last resort, where RACHA-specific activities requiring IEC support do not overlap with anyone else's (for example, the syphilis pilot test). The IEC team will identify an appropriate designer/producer and oversee the development and production of the material. A variety of public and private sector producers can be contracted for materials development, including the National Center for Health Promotion, NGOs such as CHED or Women's Media Center, or private sector design firms such as Design Group, ParaGraph, or private artists.

**CAPACITY DEVELOPMENT STRATEGIES - FOR THE LONG TERM**

**Internal capacity-building**

While there is expressed need for and verbal commitment to strengthening IEC in RACHA, it is unknown what inputs will be available in the future to support this commitment. There is not a permanent IEC advisor on the RACHA team, although is being considered. As for training, because local capacity remains low and training in IEC has not yet been a priority of donors, international training would be required to develop the national coordinators' skills.

The direction of the capacity-building should be towards communications management, not towards developing an in-house production unit. There are numerous organizations (both public and private) currently trying to build production capacity, and RACHA can support and further this local capacity development by contracting with these organizations. This approach was recommended in the draft National IEC Strategy as well.

While the IEC coordinators should remain coordinators and contract out production tasks, they still need to develop a solid understanding of each step in the development
and production process so as to be able to manage the process. Moreover, because the capacity of local agencies is still early in the development stage, contracts will require significant hands-on oversight.

? **Hire an expatriate advisor.** For the follow-on project beginning 2000, a full-time IEC/BC Advisor should be added to the RACHA team of expatriate advisors. This advisor should be of equal status and experience as the other expatriate advisors on the team.

The need for an expatriate advisor is also related to prevailing Khmer cultural features of status, hierarchy, and gender. This is because it will be difficult for the IEC coordinators to obtain access to the appropriate personnel within the MoH for technical and gatekeeper reviews and approvals, as well as effectively persuade and influence decision-makers regarding IEC technical issues (see Coordination, below).

? **Learn from local experience by initiating local study tours/exchanges with other successful projects in Cambodia as soon as possible.** In addition to the IEC coordinators, other project staff could benefit from the experience of other organizations working in Cambodia with similar objectives. For example, the Community Development Team and Community Health Promotion Team may benefit greatly from observing the Partners for Development programs in Kratie and Steung Treng.

? **Learn from South-South exchanges by sending coordinators for regional IEC training in 1999/2000.** Training opportunities for IEC in the region (possibilities include Bangkok, Indonesia's BKKBN, Philippines, Bangladesh) should be identified and the coordinators sent as appropriate. They should attend together, as one has stronger English ability than the other, and they can assist each other in translation. Moreover, if they attend together, they will be able to reinforce each others' knowledge and skills, leading to more effective transfer of training.

? **Develop international-level skills by sending coordinators to the U.S. for training next year.** In 2000, if the English language ability continues to improve, the coordinators will be ready to attend a U.S-based training course, such as the 6-week "Advances in Family Health Communication" training offered annually in June by JHU/CCP. (For this particular course, applications are required early in the year (March) so the decision to send the coordinators should be made by February 2000.)

**STRENGTHENING COORDINATION**

By taking a collaborative approach to IEC, RACHA can increase its efforts in IEC with minimal inputs. Collaboration increases the effective and efficient use of available resources through the:

a) extension of capacity and resources
b) transfer of skills / capacity building
c) reduction of costs to each organization  
d) broader dissemination of consistent messages  

It is essential that IEC materials are consistent with national standards and protocols. IEC Coordinators should be responsible for ensuring that adequate technical review by experts and gatekeepers in the MoH takes place. Moreover, IEC must be synchronized with service delivery activities – it should keep pace but never get ahead. Coordinators will also need to ensure that IEC/BC messages and products are effective, do not duplicate other materials, and meet communication objectives, which will require the ability to coordinate with other organizations. Since the elections in the summer of 1998, the RH Technical Working Group has effectively disbanded, making coordination among various agencies extremely difficult.

? **Continue to actively participate in the IEC Working Group.** Should the MoH move towards institutionalizing an IEC coordinating body (as recommended in the Draft National IEC Strategy supported by UNFPA/MSI), RACHA should be prepared to support this move.

? **Assist in reinstating the RH Technical Working Group.** RACHA would also benefit by encouraging the MoH to reinitiate the RH Technical Working Group. IEC Coordinators should be encouraged to attend meetings, where possible.

? **Take a central role in the development of a basic package of IEC materials for health centers.** Follow up with UNICEF and the MoH on the concept and have strong RACHA participation and leadership in this activity.

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**PLANNING FOR 2000 and BEYOND**

**1. External capacity building**

Because RACHA works in support of the Ministry of Health as well as in cooperation with numerous other agencies, the RACHA’s ability to conduct effective IEC activities will be limited by the in-country IEC capacity, at the planning level as well as the implementation level. One way to address capacity constraints is to make capacity development a strategic objective, and an important opportunity exists for RACHA to take the lead in developing in-country IEC training programs.

Another important reason to develop local training programs is because local staff usually do not have the English language skills to benefit from regional/international training opportunities. This constraint has hindered RACHA as well.

Developing IEC capacity is important to RACHA because:

1) The low capacity represents an obstacle that can be removed
2) RACHA, as a USAID-funded project, has the ability to tap into the expertise of other USAID-funded CAs with global expertise in IEC/BC.
3) No other organization is currently acting on this opportunity
Add IEC capacity-building as a program objective for the follow-on project. The opportunity exists to develop a training program within Cambodia, such as those established in Indonesia or Bangladesh, based on the JHU/CCP "Advances" model. Once RACHA coordinators have been trained, they can serve as key persons for the curriculum development and training, with technical assistance from external agencies with expertise in communication training.

Because it will be important to develop RACHA staff first, planning and curriculum development can begin in 2000, with the first training program initiated in 2001.

2. Improving Demand for and Access to Services – Behavior Modeling

Recognizing that poor quality of care and services is the chief deterrent to use of the public health system, and taking advantage of RACHA’s institutional strengths, RACHA should focus IEC efforts on behavior modeling for providers and clients at the health center level, by developing "centers of quality."

“Centers of Quality” For providers, behavior modeling can take a variety of shapes, but the success of the Basic Life Skills Training activity in Battambang suggests the need for such “centers of quality” is essential not only to the development of clinical skills, but also for demonstrating what good quality looks like, that it is possible in Cambodia, that the effort to provide good quality is rewarding – in short, it is essential to increasing the sense of self-efficacy among providers. To change provider behavior, they need not only the opportunity to see and practice these skills and behaviors, but also to witness ways in which changing practices can benefit them personally.

Staff suggested a number of areas in which a model or “center of quality” or “excellence” would have a positive impact:

- Select clinical skills, including infection prevention/control;
- Counseling & patient education/IEC skills
- HIS
- Management & supervision
- Integration of RH/MCH services / "Inreach"
- Client-centered services
- Community outreach

Because of RACHA’s experience with counseling, it is recommended that RACHA focus on developing a model of client-centered services with expert counseling skills.

IEC activities for clients should focus as well on providing credible models of desired behavior. Of course, behavior modeling is not a magic bullet and will not be able to surmount the many structural barriers that hinder good quality of care. Until the quality of public health services improve, efforts to model “correct” use of the health system will not be credible. Behavior modeling should be designed to empower clients to prevent illness, to improve self-care, and helping clients know what they can do to get better care from the health system.
3. Expand Community Development and Health Promotion Program

Community health promotion is: "the process of enabling people to increase control over, and to improve, their health."

No other activity that RACHA engages in has the greatest potential to achieve changes in the health status of the population. However, to do this well is a very difficult task. The community team is very dedicated and energetic, and would benefit from additional training and exposure to other programs.

a. Collaborate with PFD to redesign the health promotion curriculum with community participation, focusing on one topic at a time. The curriculum should:
   - Reflect the reality of community health beliefs, systems, and language
   - Adhere to the principles of Adult Learning
   - Allow participants to discover for themselves the causes for each problem
   - Focus on developing community members' sense of self-efficacy in solving their problems
   - Conclude with the community developing its own solutions

b. Focus on key Health Interventions – Birth Spacing/Sterilization and Diarrhea. Prevention of unwanted pregnancy is one of the few interventions with demonstrated effectiveness on maternal and child health, as well as social and economic welfare. RACHA should be prepared to stand behind birth spacing and sterilization as core activities in a RH/CH program, and consider birth spacing a high-priority activity across all activities, including SIS and community health promotion. Successful models and materials for community-based programs already exist in Cambodia, and can be easily adopted with minimum effort by the community programs team. One good model worth investigating is the one developed and implemented by the Ministry of Women's Affairs. It makes little sense for the community health promotion team to struggle in developing new materials for numerous health problems when they could already be successfully implementing a community birth spacing education program. Similarly, RACHA should continue to support sterilization activities and incorporate permanent methods into all birth spacing training and educational activities.

Currently, there is a strong programmatic effort on anemia prevention activities. However, the focus on iron and diet may not be the only or the best method to reduce anemia. Results from a recent study sponsored by UNFPA and the National Maternal and Child Health Center suggested that the most frequent cause of anemia in Cambodia may not be iron deficiency, but vitamin B-12 deficiency due to chronic diarrhea. Thus, community programs’ work in the areas of diarrhea prevention, clean water, hygiene and sanitation may, like birth spacing, have multiple impacts on maternal and child health and should be considered an essential component of any effort to reduce maternal and child morbidity and mortality. This does not necessarily mean that RACHA should itself implement full-scale water and sanitation activities, but consider creative solutions to ensuring that such activities occur in RACHA-supported provinces. Otherwise, expected gains from RACHA’s other RH/MCH interventions may fail to materialize, or be masked by the consequences of poor hygiene and sanitation.
As with birth spacing, effective models already exist. Collaboration and learning exchanges with Partners for Development (PFD), for example, is highly recommended, and PFD has indicated strong interest in collaborating with RACHA.

In summary, RACHA should focus immediate efforts on these two issues because of:

1) Proven effectiveness at directly and indirectly improving RH/MCH
2) Current availability of effective curricula and materials that can readily and successfully be implemented while building staff capacity and experience.

Once the community health promotion team has gained successful experience in implementing tried-and-proven curricula, then they can take on the task of developing new modules.

c. Integrate communication information needs into village mapping activities. Mapping of villages has sometimes included identification of communication points – importantly, TV and VCRs. While radios may be ubiquitous, the assessing the availability of TV and VCRs within communities will be important for future media/IEC planning. Future mapping activities should consistently identify these communication points.
ANNEX A: Envisioning IEC

What is IEC?

IEC is an umbrella term for three distinct, but interrelated disciplines: information, education, and communication. Information encompasses such practices as public relations, news media, library and information services, and information dissemination (such as the Reproductive and Child Health website). Education can involve the formal and non-formal educational systems, adult education and literacy. Communication encompasses for example, organizational communication, mass media, entertainment, social marketing, advocacy, and interpersonal communication and counseling. Drawing boundaries between these categories is neither practical nor useful; this point is made merely to demonstrate the interdisciplinary nature of IEC, the number of different skill areas in which an IEC manager must attain familiarity (if not expertise), and draw attention to the very large toolkit that is available to IEC specialists to influence behavior.

The IEC Process

IEC experts in various times and places have developed similar models of an effective process for planning IEC materials and activities. To date, few IEC producers in Cambodia have followed such a process, resulting in poor quality, inappropriate and ineffective materials. RACHA staff members’ reluctance to obtain and use existing materials is a symptom of the fact that, while many materials are currently produced and available, few actually meet the needs of health workers or clients.

This is changing. At the National IEC Strategy Development Workshop held in September, 1998 at the National MCH Center, workshop participants discussed the problem of poor quality materials, and recommended as one strategy to improve the quality of materials the adoption of a standard process. This process, included in the draft strategy document, involves 6 basic steps:

- Assessment
- Design
- Development & pretesting
- Distribution/implementation
- Monitoring & evaluation
- Re-assessment and replanning

Skipping any of these steps jeopardizes the quality and effectiveness of the material, which is costly because producing ineffective materials is a waste of scarce resources. Of course, simply following a process is not a guarantee of success, as each step can only be performed as well as the one preceding it. Under the usual pressure to meet deadlines and produce materials quickly, many material developers slight or skip some steps all together. It is essential, then, that managers and decision-makers as well as IEC staff become familiar with the process and the underlying rationale for each step, so that they can support IEC staff.
Approaches to IEC: Functional vs. Strategic

There are two basic orientations or approaches to IEC, the functional approach and the strategic approach. While it is clear that the strategic approach can achieve greater impact in terms of behavior change, what is not clear is whether the functional approach is a necessary predecessor to the strategic approach. It would appear that in most, if not all programs, the functional approach is taken in the early stages of a program, and the strategic approach in later stages. One key determinant of which approach can be used is the technical capacity of the IEC staff.

In the functional approach, IEC plays a support role to other program activities. It is product-oriented, and evaluated on the outputs generated. It tends to focus on producing changes in knowledge based on what experts decide, and production is frequently done in-house, with a lot of emphasis on developing internal production capacity. Thus, every NGO or ministry department develops their own IEC unit, duplicating effort and frequently creating materials with little opportunity for coordination.

In the strategic approach, there is a greater emphasis on process over product, on impact over output, and on changes in behavior instead of knowledge. IEC plays a key strategic role within an organization (instead of a peripheral or support role), and is client-oriented rather than provider or expert-oriented. Because of the technical skills required to produce this level and volume of IEC, there is a greater emphasis on contracting out the production of materials to production experts, and reorienting in-house capacity from do-it-yourself production to process management.

Re-thinking Behavior Change

It is now well-recognized that behavior change occurs in context, and that approaches that focus exclusively on individual behavior cannot have significant or sustained impact. Behavior is influenced by individual, social and structural/environmental factors, including political, economic, historical factors at local and national levels.

Structural models of behavior show that "environmental forces beyond the control of the individual constrain or help the knowledge-behavior link." Some structural factors include legal restrictions or guarantees, economic factors such as income and price, and access to services. The implication for programs is that while educating individuals may be one important strategy, changes in social structures may be more effective starting points. Thus an exclusive focus on individual behavior is tantamount to "blaming the victim." For example, inquiries into poor utilization of health services frequently lead to the conclusion that community people lack the knowledge to take care of their own health, and that the solution is to "educate" them. This type of intervention will not produce the desired results if the real reason that people avoid health services is because it is inaccessible to them, for example, as when providers refuse to treat clients who cannot pay.

The Rockefeller Foundation's 1999 publication, Communication and Social Change: A Position Paper and Conference Report, for example, calls for a shift in strategic approaches away from a focus on individual behaviors and on to social norms,
policies, cultures, and environments. This reflects not so much as "new thinking" but a reaction to recent overemphasis on individual behavior and a call for balanced approaches to behavior change. For example, the IMPACT Project's strategic framework includes interventions at four levels: individual, societal, infrastructure (health), and structural/environmental.

**Principles of Adult Education.** The principles of adult education include respect, safety, autonomy, immediacy, experience, dialogue, and accountability (see Appendix C). One principle of adult education is that you must respect the adult's existing knowledge and build on that. That in turn requires an understanding of what your audience already knows. This issue is complicated by the fact that the majority of Cambodians do not possess a belief system that includes the Western biomedical concepts and practices that RACHA wants to promote. When our clients do not behave as we desire, it is unproductive to design programs based on the conclusion that they simply "lack information." This does not respect the traditional belief system that most Khmers use to understand their health and illness, or the competence that adults have achieved within their own culture. The main idea is to find out what they already know/believe and why, and then develop education programs that respects and responds to existing knowledge.

**Focus efforts on developing self-efficacy.** Self-efficacy is a belief in one's own ability to control events or outcomes that affect their lives. It is a combination of self-confidence in one's knowledge and skills, and an internal locus of control – that is, the belief that the individual can influence or control the specific outcome (rather than the outcome being subject to forces beyond the individual's control.) (See Self-efficacy in Changing Societies, Bandura, 1995)
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<th>Program Activity</th>
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| 1. Sterilization services supported in Phnom Penh, Siem Reap, Kampot, Pursat | Services currently available. High demand for limiting, but no demand for sterilization. | Low awareness of the method, low knowledge. Fear of castration, operation/complications, unknown expense. Provider knowledge/behavior may be a barrier. | 1. Work with provincial officials to fix price on a trial basis.  
2. Interview/videotape satisfied clients.  
3. Design a coordinated hospital/provider-centered and community-based promotion of sterilization.  
4. Develop supporting materials. |
1. Identify existing materials that meet needs.  
2. For materials not available, develop support print materials for use during counseling.  
3. Following training, conduct a community publicity/recognition campaign to increase public confidence in public providers. Promotional should materials focusing on tangible benefits of going to the clinic (i.e. iron tablets, TT vaccination) rather than health benefits.  
4. Consider community-based campaign to address norms re: maternal/neonatal morbidity and mortality. |
| 3. Pilot Syphilis Testing              | No counseling materials? | “STD” a generic concept – little differentiation between different STDs. Few client-oriented STD materials. | Develop counseling support materials to:  
1. explain syphilis and the importance of testing to the client and her baby,  
2. explain treatment if testing is positive.  
3. general STD client education materials. |
| 4. Private Sector – Marketing of birth kits? |                           |                                                                        |                                                                                  |
| 5. SIS topics                          | When clients are interviewed, “can’t remember” what they were told. | Lack of client education materials for anemia. Possibly messages, counseling process, interviews can be improved. (UNICEF – wants to develop standard package of IEC materials for each level in the system) | 1. Review counseling process, messages delivered.  
2. Assess available materials; if none appropriate, then:  
3. Develop client education materials on TT, anemia and breastfeeding. (NOTE: New Maternal Record Card will have message on Anemia). |
2. Review and revise (if necessary) current program. Develop additional materials as necessary.  
3. Collaborate with PFD in future development of BS materials. |
| 7. CMA                                 | No communications plan  | Infrequent communication with members; newsletter published infrequently, too expensive. No monthly newsletter. | 1. Meet with CMA President and Executive Director to determine needs, wants;  
2. Develop communication plan for CMA |
| 8. NNT Campaign (?)                    | Special coordinated effort among multiple agencies. |                                                                        |                                                                                  |
SWOT Analysis

To look at RACHA’s institutional capacity to implement an IEC program, I assessed the strengths, weaknesses, threats and opportunities relevant to IEC.

Strengths:
? A strong interest from most program staff in increasing the level of effort in IEC.
? Rich in human resources – lot of talent, sufficient number of hands and support staff.
? Fair awareness of how improved IEC would benefit them.

Weaknesses:
? Internal IEC capacity is just beginning to develop
? Limited awareness of the IEC process, and resources required
? A “do-it-yourself” work ethic may lead to poor coordination, duplication of effort, or underutilization of external resources and expertise

Opportunities
? Coordination among various project components may improve as RACHA moves toward a common vision
? RACHA can tap into the technical expertise at other USAID-funded CAs
? Uniquely positioned to develop IEC capacity, IPC/C capacity, sterilization programs, private sector

Threats
? No full-time IEC advisor, budget for IEC activities must come from other project components
? Environment not “ready” for strategic IEC
? Broad range of needs, interventions lead to lack of focus, competing demands
? Internal politics related to turf, and cultural issues related to status threaten cross-cutting activities such as IEC
CREATIVE BRIEF

Promoting Female Sterilization

I. Audience

Primary: Married women, between 30-40 years of age with 3 or more children, who want to stop having children, in Kampot, Pursat, Siem Reap and Phnom Penh.

Secondary: Husbands, health care providers.

II. Communication Objectives

The ultimate goal is to increase the number of couples who choose sterilization as a method for limiting births, particularly where physicians have been trained by RACHA/AVSC (Kampot, Pursat, Siem Reap and Phnom Penh). Intermediate objectives include:

? to increase knowledge of female sterilization;
? to increase awareness of the benefits of female sterilization;
? to increase awareness of the availability of sterilization at 5 facilities in Phnom Penh, Siem Reap, Pursat, and Kampot; and,
? to increase the number of clients seeking information about sterilization.

III. Obstacles

While as many as 40% of women of reproductive age want no more children, only 16% use a modern birth spacing method, and fewer than 2% report using the permanent method, sterilization. Access to health services is low, and sterilization services are generally only available in the provincial capital. Quality of public health services is perceived to be very low, and potential clients fear the unknown costs and possible complications of the operation. Midwives may also have negative attitudes toward sterilization.

The main rumors/misconceptions about the method are:

? changes the woman's character – she becomes irritable
? woman becomes weak, unable to do hard work
? mental disturbances –she becomes nervous
? she becomes fat / she becomes thin
? the woman's sex drive increases/decreases
? sterilization is "castration."

The first rumor, changes in the woman's character, appears to be the most common and the most cause for concern among women and their husbands, along with fear of the operation/complications.

IV. Positioning (comparative advantage of Sterilization)

No more children! If you are sure that you do not want any more children, you can stop worrying. Now you can chose sterilization. Many women are very happy with sterilization because it is easy, safe and very effective. Sterilization is an alternative to using birth spacing methods for a long time. No forgetting, no repeat visits, no side-effects, no fasting. And, no more children!
V. **Key Promise**
With sterilization, you can "stop worrying, and start living."

VI. **Possible Support Statements / Reasons Why (to be tested)**
- Easy – come to the hospital only one time, and never worry about pregnancy again.
- Simple operation – no stay in the hospital
- Enough time to work and make money.
- Alternative to using birth spacing methods for a long time - no side-effects, no forgetting, no mistakes or accidental pregnancies.
- Happier relationship with husband (better sex life) – no 'fasting' (abstinence).
- Safe - the doctors at __________ hospital have special international training.
- For some women, pregnancy is very dangerous. Sterilization can save their lives.

VII. **Tone**
Promotional/informational. Satisfied clients will give testimonials to the ease and the benefits of the procedure. Doctors and midwives will provide factual information. The video will also show the client to expect when she comes for the procedure. Humor can be used to lighten up sensitive topics.

VIII. **Opportunities/Openings**
Women who visit the provincial hospital for birth spacing and other services watch videos while waiting. Community-based health promoters can also use the video (many rural areas have access to television and video). Some health centers may have access, or the midwives based at health centers may have access to TV/VCR in their communities. (The footage may later be reedited into a 30-second television spot for broadcasting.)

IX. **Creative Recommendations**
Currently, sterilization is perceived as a "secret," something that women know about but may be afraid to discuss openly. Emphasis should be on letting out the secret – the positive experience of other women. Possibly it can be portrayed humorously as the "Secret to a long, happy marriage," or other romantic angle.
CREATIVE BRIEF

I. Audience

Primary: Married men, between 35-45 years of age with 3 or more children, who want to stop having children, in Kampot, Pursat, Siem Reap and Phnom Penh.

Secondary: Wives, health care providers.

II. Communication Objectives

The ultimate goal is to increase the number of couples who choose vasectomy as a method for limiting births, particularly where physicians have been trained in vasectomy by RACHA/AVSC (Kampot, Pursat, Siem Reap and Phnom Penh). Intermediate objectives include:

? to increase knowledge of male sterilization;
? to increase awareness of the benefits of male sterilization;
? to increase awareness of the availability of sterilization at 5 facilities in Phnom Penh, Siem Reap, Pursat, and Kampot; and,
? to increase the number of clients seeking information about sterilization.

V. Obstacles

While as many as 40% of married women of reproductive age want no more children, only 16% use a modern birth spacing method, and fewer than 2% report using the permanent method, sterilization. Access to health services is low, and sterilization services are generally only available in the provincial capital. Quality of public health services is perceived to be very low, and potential clients fear the unknown costs and possible complications of the operation. Midwives – who counsel the majority of birth spacing clients - may also have negative attitudes toward sterilization. Many doctors and midwives believe Cambodian men will never "accept" vasectomy.

The main rumors/misconceptions about the method are:

? sterilization is "castration;" after the operation, the man won't be able to have erections/ejaculations/sex:
? a man who has the operation is not a man anymore
? the man becomes fat, lazy, weak, unable to do hard work (like pigs/animals)
? providers believe men won't accept vasectomy
? sterilization increases/decreases a man's sex drive
? a man who is sterilized becomes "nervous," has mental problems
? it's the woman's responsibility

The first rumor, vasectomy is castration, appears to be biggest obstacle to the use of the method. Even providers refer to vasectomy as "castration." Linguistically, there is no appropriate word for vasectomy in Khmer.

VI. Positioning (comparative advantage of Sterilization)

Cambodian men who have enough children have chosen vasectomy. They are very happy because it is easy, safe and very effective. They can have sex any time, and their
wives won’t be afraid of getting pregnant. No more “fasting,” you are free to enjoy!

V. **Key Promise**
With vasectomy, you can be free!

VI. **Possible Support Statements / Reasons Why (to be tested)**
- Easy – only takes 15 minutes!
- Not castration – nothing is removed
- Still a strong, healthy man, in all ways!
- Very effective – no more worrying!
- Your wife can relax and enjoy sex – improve your sex life!
- Safe - the doctors at _________ hospital have special international training.
- If your wife has a medical problem, vasectomy may be the best method. Vasectomy may save your wife.

X. **Tone**
Promotional/informational. Satisfied clients will give testimonials to dispel the myth of castration, and discuss the ease and the benefits of the procedure. Doctors and midwives will provide factual information. Humor can be used to discuss sensitive topics – such as sexual relations between husband and wife - but care must be taken not to make vasectomy a “joke.”

XI. **Opportunities/Openings**
Wives and some men who visit the provincial hospital for birth spacing and other services watch videos while waiting. Community-based health promoters can also use the video (many rural areas have access to television and video). Some health centers may have access, or the midwives based at health centers may have access to TV/VCR in their communities. (The footage may later be re-edited into a 30-second television spot for broadcasting.)

XII. **Creative Recommendations**
Currently, sterilization is perceived as castration, and men who have chosen vasectomy try to keep it a secret for fear of ridicule. Emphasis should be on dispelling the rumor that vasectomy is castration, and clearly demonstrate the differences between vasectomy and castration. The positive experience of other men will be used to dispel fears and promote the benefits. Possibly it can be portrayed humorously as the “Secret to a happy marriage,” or other romantic angle.