HEALTH COMMUNICATION CAPACITY COLLABORATIVE

Demand Generation for Reproductive, Maternal, Newborn and Child Health Commodities

UTILIZING ICT IN DEMAND GENERATION FOR REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH:

THREE CASE STUDIES AND RECOMMENDATIONS FOR FUTURE PROGRAMMING

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Contents

Acronyms

CHPS	Community-based Health Planning & Services
CHWs	Community Health Workers
GSM	Global System for Mobile
HCAC	Health Content Advisory Council
ICT	Information Communication Technology
IVR	Interactive Voice Response
MAMA	Mobile Alliance for Maternal Action
MOTECH	Mobile Technology for Community Health
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBCC	Social Behavior Change and Communication
SMS	Short Message Service
UNCoLSC	United Nations Commission on Life-Saving Commodities for Women and Children
USSD	Unstructured Supplementary Service Data
WRHI	Wits Reproductive Health & HIV Institute

About

What is this resource?

This resource provides an in-depth look at three programs that illustrate the use of Information and Communication Technologies (ICTs) and new media, specifically using mobile technologies, as part of an integrated strategy to increase demand for and use of reproductive, maternal, newborn and child health (RMNCH) commodities and services. The three case studies are:

1) Mobile Alliance for Maternal Action (MAMA), which uses technology to improve health and nutrition outcomes among pregnant women and new mothers and their infants in Bangladesh and South Africa;
2) Ananya, which is a multiplatform program designed to reduce maternal and infant mortality in Bihar, India; and
3) Mobile Technology for Community Health (MOTECH), which aims to increase the quantity and quality of prenatal and neonatal care in rural Ghana.

Who should use this resource?

This guide is intended for program managers, planners and other professionals involved in the design, implementation, or evaluation of demand generation programs that work to improve the demand for and utilization of RMNCH commodities and services.

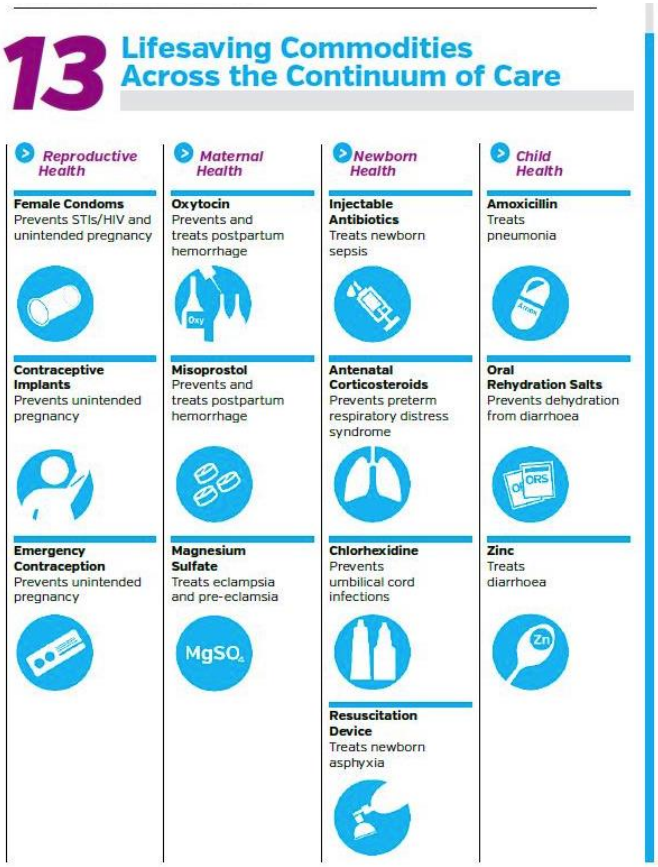
How do I use this resource?

The three case studies provide examples on how to use technology as part of a larger, integrated communication strategy for demand generation. They also provide examples on how to apply behavior change theory to demand generation programs. The essence of this resource is captured in the last section highlighting key lessons learned from all three case studies with recommendations for future ICT programs.

This resource serves as an important tool in the Demand Generation Implementation Kit for Underutilized Commodities in RMNCH (www.sbccimplementationkits.org/demandRMNCH), which is designed to support the development of country-specific communication strategies to increase demand for under-utilized commodities in RMNCH.

Thirteen Life-Saving Commodities for Women and Children

In 2010, the United Nations (UN) Secretary-General's *Global Strategy for Women's and Children's Health* highlighted the impact that a lack of access to life-saving commodities has on the health of women and children around the world. The Strategy called on the global community to save 16 million lives by 2015 through increasing access to and appropriate use of essential medicines, medical devices and health supplies that effectively address leading avoidable causes of death during pregnancy, childbirth and childhood. Under the Every Woman, Every Child (EWEC) movement and in support of the Global Strategy and the Millennium Development Goals (MDGs) 4 and 5, the UN Commission on Life Saving Commodities for Women and Children's Health was formed in 2012 to catalyze and accelerate reduction in mortality rates of both women and children. The Commission identified 13 overlooked life-saving commodities across the RMNCH 'Continuum of Care' that, if more widely accessed and properly used, could save the lives of more than 6 million[1] women and children. For additional background information on the Commission please refer to: http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities



[1] For assumptions used to estimate lives saved see UNCoLSC Commissioner's Report Annex (http://www.everywomaneverychild.org/images/UN_Commission_Report_September_2012_Final.pdf)

An Overview of Demand Generation

Demand generation increases awareness of and demand for health products or services among a particular intended audience through social and behavior change communication (SBCC) and social marketing techniques. Demand generation can occur in three ways:

- Creating new users - convincing members of the intended audience to adopt new behaviors, products or services;
- Increasing demand among existing users - convincing current users to increase or sustain the practice of the promoted behavior and/or to increase or sustain the use of promoted products and services;
- Taking market share from competing behaviors (e.g. convincing caregivers to seek health care immediately, instead of not seeking care until their health situation has severely deteriorated or has been compromised) and products or services (e.g. convincing caregivers to use oral rehydration solution (ORS) and zinc instead of other anti-diarrhea medicines).

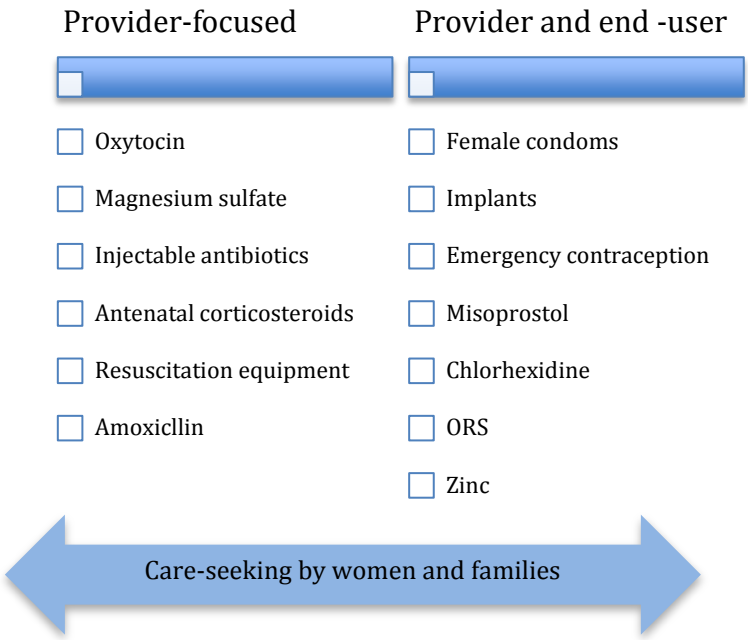
Demand generation programs, when well-designed and implemented, can help countries reach the goal of increased utilization of the commodities by:

- Creating informed and voluntary demand for health commodities and services;
- Helping health care providers and clients interact with each other in an effective manner;
- Shifting social and cultural norms that can influence individual and collective behavior related to commodity uptake; and/or
- Encouraging correct and appropriate use of commodities by individuals and service providers alike.

In order to be most effective, demand generation efforts should be matched with efforts to improve logistics and expand services, increase access to commodities, and train and equip providers in order to meet increased demand for products and/or services. Without these simultaneous improvements, the intended audience may become discouraged and demand could then decrease. Therefore, it is highly advised to coordinate and collaborate with appropriate partners when forming demand generation communication strategies and programs.

Who are the audiences of demand generation?

Reducing maternal and child morbidity and mortality through increased demand for and use of RMNCH commodities depends on the collaboration of households, communities, and societies, including mothers, fathers and other family members, community and facility-based health workers, leaders, and policy makers. Some of the commodities are more provider-focused in terms of demand and utilization, but all depend on care-seeking by women and families.



Key Concepts and Definitions in Demand Generation

Social and Behavior Change Communication (SBCC). SBCC promotes and facilitates behavior change and supports broader social change for the purpose of improving health outcomes. SBCC is guided by a comprehensive ecological theory that incorporates both individual level change and change at the family, community, environmental and structural levels. A strategic SBCC approach follows a systematic process to analyze a problem in order to define key barriers and motivators to change, and design and implement a comprehensive set of interventions to support and encourage positive behaviors. A communication strategy provides the guiding design for SBCC campaigns and interventions, ensuring communication objectives are set, intended audiences are identified, and consistent messages are determined for all materials and activities.

Social Marketing. Social Marketing seeks to develop and integrate marketing concepts (product, price, place, and promotion) with other approaches to influence behaviors that benefit individuals and communities for the greater social good. (http://socialmarketing.blogs.com/r_craiig_lefebvres_social/2013/10/a-consensus-definition-of-social-marketing.html)

Channels and approaches:

> ***Advocacy.*** Advocacy processes operate at the political, social, and individual levels and work to mobilize resources and political and social commitment for social and/or policy change. Advocacy aims to create an enabling environment to encourage equitable resource allocation and to remove barriers to policy implementation.

Community Mobilization. Community mobilization is a capacity-building process through which individuals, groups, or organizations design, conduct and evaluate activities on a participatory and sustained basis. Successful community mobilization works to solve problems at the community level by increasing the ability of communities to successfully identify and address its needs.

Entertainment Education*.* Entertainment education is a research-based communication process or strategy of deliberately designing and implementing entertaining educational programs that capture audience attention in order to increase knowledge about a social issue, create favorable attitudes, shift social norms, and change behavior.

Information and Communication Technologies (ICTs). ICTs refer to electronic and digital technologies that enable communication and promote the interactive exchange of information. ICTs are a type of medium, which include mobile and smart phones, short message service (SMS), and social media such as Facebook and Twitter.

Interpersonal Communication (IPC). IPC is based on one-to-one communication, including, for example, parent-child communication, peer-to-peer communication, counselor-client communication or communication with a community or religious leader.

Mass and Traditional Media. Mass media reaches audiences through radio, television, and newspaper formats. Traditional media is usually implemented within community settings and includes drama, puppet shows, music and dance. Media campaigns that follow the principles of effective campaign design and are well executed can have a significant effect on health knowledge, beliefs, attitudes, and behaviors.

Growth of ICT and new media and potential to increase demand

ICTs are electronic, digital technologies that include standalone computing as well as telecommunications technologies, such as mobile and smart phones, that enable the creation and exchange of information. ICTs provide the platform for new media, which include websites, chat rooms, online communities and mobile messaging that, in comparison to traditional media like radio or television, are interactive and empowering. Given the global proliferation of mobile and wireless technologies, ICTs and new media have the potential to transform health communication and service delivery. There are now over five billion wireless subscribers around the globe, and over 70% of them reside in low- and middle-income countries. Over 85% of the world's population is covered by commercial wireless signals, much more than is covered by a network of roads or by the electrical grid (WHO, 2011). ICTs and new media offer methods for connecting and mobilizing consumers and providers – even those living in hard-to-reach areas – and reaching them with up-to-date health information.

ICT and new media concepts

Media/Medium. Media/medium refers to the means of communication, such as radio, television, print, web-based tools, and face-to-face communication that may reach or influence people widely.

Channel. Channels are the means of transmission of media, such as cable, wire, and radio waves.

e-Health. Electronic health, e-Health, is the use of information and communication technologies (ICT) for health.

m-Health. Mobile Health, m-Health, is the provision of health services and information via mobile and wireless technologies.

Information and Communication Technology (ICT). ICTs refer to electronic, digital technologies including standalone computing and telecommunications technologies which enable communication and promote the interactive exchange of information. ICTs are a type of medium which include mobile and smart phones, SMS and social media such as Facebook and Twitter.

New media. New media is a term for the various forms of electronic, interactive communication that are made possible through the use of computer and web-based technology (i.e. websites, chat rooms, online communities). The term is in relation to "old" media forms, such as print newspapers and magazines, which are static representations of text and graphics.

Social media. Social media refers to interaction among people in which they create, share, and/or exchange information and ideas in virtual communities and networks.

Case Study #1: Mobile Alliance for Maternal Action (MAMA)

Using Mobile Phones to Improve Health

The MAMA Program uses technology to improve health and nutrition outcomes among pregnant women and new mothers and their infants in resource-poor settings. MAMA delivers vital and culturally-sensitive health messages to expectant and new mothers via mobile phones. The messages reflect the most up-to-date, evidence-based global standards and relate to behaviors that are proven to affect health outcomes, such as attendance at antenatal care, nutrition, vaccination, cord care, and use of insecticide-treated bed nets.

Context

MAMA is currently being implemented in two countries with high maternal and infant mortality rates and widespread cellular coverage – Bangladesh and South Africa. MAMA India is expected to launch in 2014.

Bangladesh

In Bangladesh, pregnant women and new mothers do not often have access to timely, reliable and culturally relevant information about how to best care for themselves and their babies. Although there has been some improvement over the past ten years, maternal and infant mortality rates are still very high. In 2010, the lifetime risk of maternal death was 1 in 170 women. In 2011, the infant mortality rate was 37/1,000 infants (UNICEF, 2013). Mobile phone access and cellular coverage has expanded exponentially in the last ten years and offer a means to reach Bangladeshi women with lifesaving information.
In 2000, Bangladesh had one of the lowest tele-density rates in the world: 0.26 telephones per 100 inhabitants. However, since then, Grameenphone has become the leading wireless operator in Bangladesh, with a network covering over 90% of the population (IDA, 2007). In September 2013, Grameenphone announced the opening of its 3G network in Dhaka, which will enable the rollout of a nationwide 3G network with enhanced capacity and instant mobile Internet access for all customers (Xinhuanet News, 2013).

Photo Courtesy of MAMA

Prior to the national launch in December 2012, MAMA Bangladesh conducted formative research in 13 locations in four districts (Dhaka, Chittagong, Sylhet, and Gaibandha). Among approximately 1,000 subscribers, 60% of women had their own phone, with the other women enrolling through a gatekeeper/family member's phone. Willingness to pay for the service was low, but poor

subscribers were willing to pay more than high-income subscribers. Household decision makers were willing to pay more than women (Mendoza, 2013). Reasons for these findings were not revealed in the literature, however, research suggested that once a subscriber begins receiving the service, his/her threshold for payment increases thus suggesting that a model using an initial free trial might gain higher retention and eventual willingness to pay.

South Africa

Similar to Bangladesh, maternal and infant mortality rates are very high. In 2010, the lifetime risk of maternal death was 1 in 140 women, and in 2011, 35 out of every 1,000 infants died before their first birthday (UNICEF, 2013). The South African Department of Health has identified addressing maternal and child mortality as one of its four priorities (MAMA South Africa, 2013). More South Africans use a mobile phone than watch television or listen to the radio, and there are more SIM cards in use in South Africa than people (MAMA South Africa, 2013).

OVERVIEW OF THE MAMA PROGRAM

Location: Bangladesh and South Africa

Partners: United States Agency for International Development (USAID), Johnson & Johnson, United Nations Foundation, and BabyCenter; operates through a secretariat hosted by the mHealth Alliance.

Launch Date: May 2011

Summary: The MAMA partnership has developed adaptable messages that are based on WHO and UNICEF guidelines. The messages have been developed in close collaboration with a group of global health experts who make up MAMA's Health Content Advisory Council (HCAC). MAMA's HCAC members lend their knowledge and expertise to ensure that MAMA's messages reflect the most up-to-date, evidence-based global standards. Messages relate to behaviors that are proven to affect health outcomes, such as attendance at antenatal care, nutrition, vaccination, cord care, and use of insecticide-treated bed nets. The messages blend health with child development information so mothers are motivated to get the right care at the right time for themselves and their children. Messages are consistent with national and state behavior change and communication strategies and are aimed to be endorsed by host country governments. The messages include direct reference to consumer-facing life-saving commodities such as oral rehydration solution, zinc, chlorhexidine, contraceptive implants, and emergency contraception.

The MAMA partnership has engaged the global community to help mothers and their family members subscribe to these evidence-based messages. MAMA messages located on the website are offered free of charge, and any organization can apply to adapt and use the messages in their own local programs. Messages are available through www.mobilemamaalliance.org. The cost of subscribing is based on country business models and the amount of government subsidies.

Goal: At the local level, MAMA's goal is to use technology to improve health and nutrition outcomes among pregnant women and new mothers and their infants in resource-poor settings by delivering vital and culturally-sensitive health messages to new and expectant mothers via their mobile phones. At the global level, MAMA seeks to achieve "scale, sustainability and impact" by creating a replicable model for reaching low-income mothers and household decision-makers by increasing the impact of current

mHealth programs, providing technical assistance to new mHealth models, and improving methods of applying mobile technology to protect maternal health.

ICT Approach: Use mobile phones to deliver time-sensitive, stage-based information on critical health issues directly to expectant and new mothers.

Implementation

MAMA is implemented in each country based on the availability of financial and technical inputs and the necessary mobile network infrastructure. The first steps of setting up a MAMA program include establishing in-country partnerships, selecting business models and identifying mobile platforms . Depending on the country, business models can take many different shapes and are based on a collection of financial inputs including in-country government contribution, funding, subsidies by mobile operators, and minimal subscriber charges. Once the program is set up, the target population and key focus of the messages to be delivered are identified by the various country partners that provide the technical input for the program. MAMA considers multiple services, products, and applications to reach all members of the target audience.

Bangladesh: Nationwide SMS/IVR mobile application

Aponjon, the Bangladeshi version of MAMA, utilizes short message service (SMS) and interactive voice response (IVR), a technology that allows a human caller to interact with a computer through the use of voice and tones based on keypad selections. SMS and IVR can be accessed from any mobile phone handset with no special software required.

Aponjon ran as a pilot program from September 2011 to June 2012. It was implemented in four districts across Bangladesh and had 1,043 subscribers. MAMA Bangladesh was officially launched nationwide in December 2012 (MAMA Bangladesh, 2013).

Primary subscribers (pregnant women and new mothers) receive two messages per week, while gatekeepers (husbands and mother-in-laws) receive an additional weekly message if they opt in for a total of three messages per week. Information is delivered via text message or short, pre-recorded voice message skits. During the skits, local actors play the role of family member, patient, and physician in an entertaining and educational way (MAMA Bangladesh, 2013). Community health workers (CHWs) encourage women to subscribe to MAMA.

The service costs two taka (about US 2.5 cents) per message and subscribers are charged based on socioeconomic status (MAMA Bangladesh, 2013). About 20% of subscribers in Bangladesh are eligible to receive free messages (MAMA, n.d.).

South Africa: SMS, online portal, and interactive quiz service

The MAMA program is implemented in South Africa by three organizations: Praekelt Foundation, Cell-life and the Wits Reproductive Health and HIV Institute (WRHI). Following a pilot program, MAMA South Africa was launched nationwide in May of 2013. Currently, the service consists of a free SMS program offered through two inner-city clinics in Hillbrow, Johannesburg; a dynamic community portal or mobisite at www.askmama.mobi; and an interactive quiz service (MAMA South Africa, 2013). MAMA South Africa also plans to expand their services to Mxit, a popular social networking site for youth.

SMS: For subscribers of the MAMA program from the two clinics in Hillbrow, Johannesburg, MAMA SMS service sends two messages per week from the time a woman is in her fifth week of pregnancy until her child is one year old. HIV-positive mothers can receive information specifically tailored to their health needs. Due to the high costs, MAMA South Africa is unable to offer text messages free of charge nationwide, yet this is a goal for the future. MAMA South Africa will expand to include voice services for mothers with low literacy (MAMA South Africa, 2013).

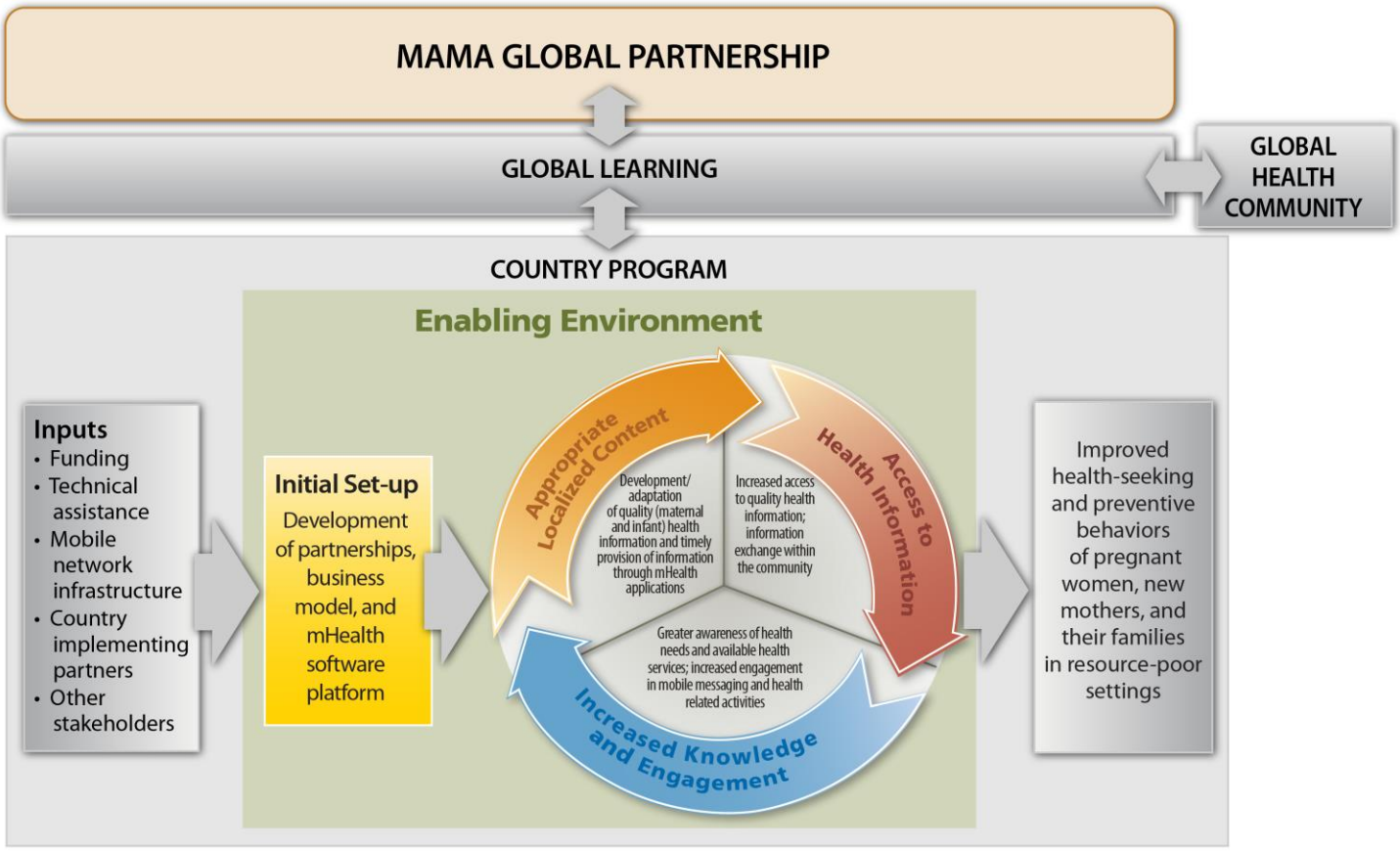
MAMA Mobi: MAMA mobi is an interactive website that delivers personalized health information to mothers in English, and will add Zula, Xhosa, and Afrikaans in the future (Cheers, 2013). By registering with a due date or baby's age, presentation of information on the site is tailored to provide relevant, personalized information based on the stage of pregnancy or age of baby (MAMA South Africa, 2013). A new partnership with Vodacom will make www.askmama.mobi available free of charge to all Vodacom subscribers in South Africa – an estimated 25 million people. The www.askmama.mobi site launched on Vodacom Live! (Vodacom's mobile homepage) on 26 August 2013 and attracted 170,000 new users in the first six weeks (MAMA South Africa, 2013).

MAMA Quizzes: Quizzes are a personalized and convenient way to learn and test individual knowledge about pregnancy and the first year of a baby's life. Subscribers dial in every "MAMA Monday" for a weekly quiz and tips from MAMA (MAMA South Africa, 2013). The quiz service utilizes unstructured supplementary service data (USSD) which is a protocol used by Global System for Mobile (GSM) cellular telephones. This protocol enables a mobile phone to communicate with a computer run by a service provider in a real-time connection. Unlike SMS messages, a USSD session allows for a two-way exchange of a sequence of data, which makes it more responsive than SMS.

MXit: In the future, MAMA will be expanding to MXit – a popular mobile social network in South Africa – to provide pregnancy, childbirth, and parenting information to users between the age of 18 and 25 (MAMA South Africa, 2013).

Theory of Change Model

MAMA's overall theory of change model is described in Figure 1 below (MAMA, 2011).



This model serves as the program guide for design and implementation of activities. The model proposes a sequence of activities – from inputs to outcomes – that take place within the policy and socio-cultural context of a given geographic location.

After inputs and initial set-up, the model addresses three stages critical for adoption of targeted behaviors: 1) Presence of appropriate localized content; 2) Increased access to health information; and 3) Increased knowledge and engagement. The theory behind these steps is that, with access to high-quality information, women will be more aware of their health needs, status and recommendations for their particular stage of pregnancy and/or motherhood and will utilize this information to change their behavior (e.g., seek preventative care, end negative health behaviors such as smoking, drinking, etc.)

This model assumes that women will want to change their behaviors based on pregnancy stage or motherhood and that effective health communication and appropriate messages will ensure improvements in health-related behavior and overall health status.

The process follows the pathways proposed by behavior change and communication theories - namely, the Health Belief Model and Theory of Reasoned Action/Theory of Planned Behavior. According to the Health Belief Model, individuals will be more likely to change their behavior if they recognize the existence of a risk, feel susceptible to that risk, and if they believe the benefits of

change outweigh the barriers to change. According to the Theory of Reasoned Action/Theory of Planned Behavior, and individual's attitude about a specific behavior and what their reference groups think of that behavior influence their intention to change and their ultimate behavior.

Results

MAMA has developed adaptable messages informed by experts in maternal, newborn, and child health. These evidence-based, culturally-sensitive mobile messages are being downloaded and used by 250 organizations in 60 countries around the world, accompanied by guidelines on how to localize the messages for a specific country context. MAMA's national programs in Bangladesh and South Africa currently reach over 376,000 mothers and families (MAMA, 2013).

Bangladesh

To date, 1,500 CHWs have been trained to register subscribers and over 176,000 individuals have subscribed to the service. Seventeen percent of subscribers live below the poverty line. It is projected that two million subscribers will be registered by the end of 2015. Seventy-eight percent of those who registered for MAMA through a CHW opted to receive messages in an IVR format. More highly educated women and women living in urban areas were more likely to receive messages via SMS (Mendoza, 2013).

South Africa

From the launch of the pilot program to October 2013, over 200,000 women have used the MAMA South Africa service. Detailed user testing took place during the pilot program with 22 pregnant women and new mothers over a period of two months. Eighty percent of these women reported that the service gave them new knowledge about pregnancy and how to care for a child (e.g., signs of labor, importance of a facility-based delivery, when to introduce solid food, vaccination schedules, etc.). All mothers reported sharing the information with others in the community. A formal evaluation is forthcoming that will sample more than 2,000 women to assess the health impact of the messaging regarding the adoption of health behaviors and uptake of health services.

Case Study 2: The Ananya Program

A Multi-platform Approach to Reduce Maternal and Infant Mortality in Bihar, India

Targeting providers and consumers, the Ananya Program uses mobile technologies to increase knowledge of health providers and mass media to educate consumers in an effort to generate demand for, and utilization of, maternal, infant and child health services.

Context

Bihar, India is one of the poorest regions in India; 40% of its population lives below the poverty line and 80% live in rural areas (BBC Media Action, 2012). There are 27 million women of reproductive age and 18.5 million children under the age of six living in Bihar. Although Bihar accounts for only 8% of India's population, 12% of maternal deaths and 12% of infant deaths occur in the state. Moreover, 13% of all partially immunized children and 15% of all underweight children in India reside in Bihar (Smith et al., 2011).

Reaching women in Bihar with traditional media is difficult; only 18% of women aged 15–45 watch TV and only 11% listen to the radio. However, 90% of young mothers have mobile phones (MacPherson & Chamberlain, 2013).

Equally important is the fact that all 200,000 CHWs in rural Bihar either own, or have access to, a mobile phone. The average CHW in Bihar is a middle-aged woman with a basic education, a high caseload of about 1,000 people and with little access to adequate training and materials (MacPherson & Chamberlain, 2013). These health workers are responsible for providing health information and care to thousands of people who might otherwise have limited or no access to care. When used strategically, mobile health applications can support both CHWs and the clients they serve and reinforce health messages being disseminated through other media channels.

Overview of the Ananya Program

Ananya: A Sanskrit word meaning "unique" or "unlike others"

Location: Bihar, India

Funder: Bill & Melinda Gates Foundation, with BBC World Service Trust as a partner

Implementation Dates: 2010-2015

Summary: Previously known as the Family Health Initiative, the Ananya program addresses both supply- and demand-side barriers to increased uptake, coverage, and quality of family health interventions through a synergistic set of six complementary grants. This case study focuses on the demand-side grant

focused on changing behaviors, social norms, and self-efficacy to support family health through a multi-channel communication strategy. More information on the Ananya program can be found at www.ananya.org.in

Goal: To reduce maternal, newborn, and child mortality by 40% by 2015 by addressing critical gaps in care during the most vulnerable time of life – the thousand-day window from conception, through pregnancy, the birth of a baby, to the child's second birthday. The emphasis is on family planning, pre- and post-delivery care for mothers and newborns, immediate and exclusive breastfeeding, care and nutrition for children up to two years, and routine immunization. Coverage for treatment of diarrhea and pneumonia and some neglected diseases and sanitation are also a part of the program.

ICT Approach: Incorporating the use of mobile technologies into a package utilizing various communication channels, including mass media, radio, television, and street theater, as well as uniquely tailored outreach platforms to reach and empower women. The mobile components include *Mobile Academy* (training course for CHWs), *Mobile Kunji* (CHW job aide), and *Kilkari* (message service for families).

Implementation

The Ananya Program takes a "360-degree approach" to improving maternal, newborn, and child health. BBC Media Action utilizes a combination of face-to-face communication, ICT, mass media and community work to deliver lifesaving messages to the women of Bihar. The three main program components are to (1) empower CHWs and reach families through mobile applications; (2) deliver critical messages through mass media (TV and radio); and (3) engage and mobilize the community through street theater performance and women's listener clubs.

The program was initially launched in eight priority districts in Bihar: Patna, Begusarai, Khagaria, Samastipur, East Champaran, West Champaran, Gopalganj and Saharsa. According to a news article in June 2013, the Gates Foundation announced program expansion to seven additional districts: Siwan, Sheohar, Muzaffarpur, Munger, Jehanabad, Darbhanga and Bhagalpur (Telegraph, 2013). The overall program plan is to scale-up the program to all thirty-eight districts of Bihar by 2015.

Empower CHWs through mobile applications

Mobile Academy is a training course to expand and refresh CHWs' knowledge of 10 life-saving behaviors and enhance their communication skills. Launched in May 2012, Mobile Academy uses IVR, a technology that allows a human caller to interact with a computer through the use of voice and tones based on keypad selection that can be accessed from any mobile phone handset. To access Mobile Academy, CHWs make a call that costs less than US $0.01, about 90% less than standard IVR rates; however, health workers must cover that cost themselves. Workers complete a 190 minute training course at their own pace, either during a single phone call or multiple phone calls.

Mobile Kunji, which means "guide" or "key" in Hindi, is a job aid that combines IVR-based mobile service and an illustrated deck of cards supporting key maternal and child health messages. When

visiting a family, a CHW dials the individual shortcode printed on each card and a health message plays for the family. Messages are pre-recorded by "Dr. Anita," an engaging but authoritative female doctor. The messages reinforce the information that a health worker tries to convey to a family (MacPherson & Chamberlain, 2013).

Mobile Kunji and Mobile Academy were rolled out via intensive three-day in-person trainings designed to improve the interpersonal skills of CHWs. Forty thousand CHWs in eight priority districts in Bihar were initially trained. By December 2015, it is expected that an additional 160,000 CHWs in Bihar will be trained on these mobile applications.

During formative research for the project, CHWs said that they could not afford to pay for the ongoing use of Mobile Kunji and felt the government should be required to cover the costs because it is the families who benefit from the mobile service. In response, the Gates Foundation covered the cost of calls to Mobile Kunji for the first year of the program to demonstrate the efficacy of the service to the government, particularly within poor communities that might not otherwise be able to afford mobile technology services themselves. Due to health workers' enthusiastic response to the service and up-take rates that far exceeded projections, the government of Bihar agreed to cover health workers' costs to call Mobile Kunji on an on-going basis (MacPherson & Chamberlain, 2013).

Reaching families through mHealth

Families with pregnant women and mothers of children under the age of one can also subscribe to a separate mobile service called *Kilkari* (which means a baby's gurgle in colloquial Hindi). The service focuses on promoting healthy behaviors and generating demand for health services. Subscribers to the Kilkari program receive weekly IVR calls in their local language about maternal and child health. These calls convey information that is appropriate to either the gestational age during pregnancy or the child's age after birth. The staged messages reinforce the information imparted by the CHW during home visits, remind subscribers of healthy behaviors, and encourage them to follow the schedule of care recommended by the Bihar Ministry of Health. This service is accessible to about 90% of subscribers in Bihar from any mobile phone for a minimal fee; Kilkari costs 1 rupee per message ($0.02 US).

Mass media and community-based interventions

The mHealth components described above complement the mass media and community-based interventions also being implemented in Bihar as part of the Ananya Program. The mobile applications reinforce the health messages being communicated to families in Bihar as part of seven communication campaigns that will take place through 2015. Communication campaign topics focus on spacing pregnancies, preparing for the birth of a child, and reinforcing messages that CHWs deliver during home visits. A long-format radio program also educates listeners about critical maternal and child health issues, and these issues are discussed in women's listening clubs. Ten thousand performances by local street theatre companies are also planned to engage families through interactive and entertaining performances that communicate critical family health information.

Theory of Change Model

As previously noted, ICTs and new media can be most effective when incorporated into a demand generation program that incorporates multiple communication channels tailored to audience needs and linked to existing health services.

One of the objectives of Ananya is to develop and implement mass media and mobile messaging strategies at the population level. The activities implemented to achieve this objective are: 1) Develop and implement multi-media communication strategy, channels, and messages; 2) Create mobile-based communication services; and 3) Develop private sector partnerships for distribution of behavior change communication messages.

The expected output of these activities is increased reach of family health messages through mass media and mobile-based channels. The outcomes are numerous and include increased awareness of family health services at the individual/household level, increased number of family health interactions at the community and facility level, and increased adoption of positive family health behaviors at the community/population level. The expected impacts are reduced mortality and improved health outcomes.

Scale-up is also a critical piece of the Ananya initiative. As evidenced in the logic model, a key assumption is that the program can be brought to scale and that delivery at scale of high-impact family health services and interventions will significantly reduce maternal, neonatal, and child mortality and morbidity. After program implementation and scale-up throughout Bihar, Mathematica Policy Research, Inc. will undertake a rigorous process evaluation to measure the extent to which scale-up occurred, to understand and document the scale-up process, and to identify factors that facilitated and inhibited scale-up in Bihar.

Results

Mathematica Policy Research, Inc. is conducting the evaluation of the Ananya program. Although it is too early to report the full health impacts of the program, results are promising.

From August 2012 to February 2013, use of Mobile Academy and Mobile Kunji was eight times higher than expected. Although only 40,000 workers were initially trained to use Mobile Kunji, almost 75,000 unique users called Mobile Kunji in that initial seven-month period. Additionally, 1.4 million minutes of messages were played in this period (each message in Mobile Kunji is just over a minute long) (MacPherson & Chamberlain, 2013). As described above, the government pays for the cost of calls to Mobile Kunji.

Despite the fact that CHWs must pay out of their own pocket to call Mobile Academy, 21,500 workers called the service during the initial seven-month period. Those callers accessed more than 1.7 million minutes of content. Of the 21,500 callers to the service, 22% (4,730 callers) have already completed the Mobile Academy course and are eligible for certificates indicating that they passed the course (MacPherson & Chamberlain, 2013).

Anecdotal evidence is also pointing to the impact of these services on health. A physician and senior supervisor of health workers in the district of Gopalganj reported a spike in women coming to the local health facility after implementation of Mobile Academy and Mobile Kunji. This supervisor attributes the spike to the increased effectiveness of the health workers, almost all of whom have completed the Mobile Academy course. One pregnant woman also reported being convinced by her health worker and Mobile Kunji to register for free government health products and services (MacPherson & Chamberlain, 2013).

Case Study #3: Mobile Technology for Community Health (MOTECH)

Supporting Providers and Clients in Ghana

The Mobile Technology for Community Health (MOTECH) initiative aims to determine how to use mobile phones to increase the quantity and quality of prenatal and neonatal care in rural Ghana, with a goal of improving health outcomes for mothers and their newborns. The ICT approach includes mobile applications targeted at both health consumers and health providers.

Context

Ghana has made great strides in providing health care for its 25 million citizens. However, despite dedicated efforts, critical health issues remain, including the number of women who die in childbirth. In 2010, a woman's lifetime risk of maternal death was 1 in 68. In 2011, the infant mortality rate was 52/1,000 (UNICEF, 2013).

Although mobile phone penetration has quickly surpassed that of landlines in Ghana, mobile phone ownership is not yet ubiquitous in rural Ghana and, although some pregnant women own their own mobile phone, it is more common for a phone to be shared by a family, or even an entire community in some cases. A common practice is "flashing", which refers to the act of deliberately calling someone for a few seconds so that the phone rings and then hanging up before the recipient answers, indicating that the receiver of the missed call should return – and thus pay for – the call. Some studies estimate that "flashes" comprise 20-30% of all calls made in Africa (Grameen Foundation, 2012).

Overview of the MOTECH Initiative

Location: Ghana

Partners: Ghana Health Service, Grameen Foundation and Columbia University's Mailman School of Public Health. Funded by a grant from the Bill & Melinda Gates Foundation

Launch Date: July 2010

Summary: MOTECH is an open source software program that aims to distribute health information to underserved populations. MOTECH provides a set of services encompassing five key functional mHealth areas including behavior change and demand generation, management of patient data, workforce performance, last-mile supply chain, and patient adherence. Additional information on the MOTECH initiative can be found at ghsmotech.org

Goal: The MOTECH initiative aims to determine how to use mobile phones to increase the quantity and quality of prenatal and neonatal care in rural Ghana, with a goal of improving health outcomes for mothers and their newborns, striving to promote utilization of health information services in order to increase the demand for care.

ICT Approach: The ICT approach includes two mobile applications. *Mobile Midwife* provides relevant health information to women during pregnancy. The *Nurses' Application* enables health workers to use mobile phones to maintain electronic records and retrieve patient information.

Implementation

The MOTECH system was launched in July 2010 in the Kassena-Nankena and neighboring Kassena-Nankana West districts which include 27 Community-based Health Planning and Services (CHPS) facilities and eight health centers. MOTECH has since been launched in the Awutu Senya District in the Central Region and may potentially be launched nationally (Grameen Foundation, 2012). A unique component of the MOTECH platform is its simplicity; existing programs are able to adapt and integrate the MOTECH platform without having to devote intense resources to design. It is simple for the developers as well as the end user.

MOTECH provides two integrated mobile health services: *Mobile Midwife* focuses on the client and *Nurses' Application* focuses on the provider.

Mobile Midwife

The *Mobile Midwife* service enables pregnant women and their families to receive messages via SMS or IVR, a technology that allows a human caller to interact with a computer through the use of voice and tones based on keypad selections. The Mobile Midwife service is offered free of charge to users (Grameen Foundation, 2012).

Weekly messages provide information specific to the woman's stage of pregnancy and/or newborn's age. The messages are a mixture of:

- Alerts and reminders for care seeking (e.g., reminders to go for specific treatments, such as prenatal care or a tetanus vaccination).
- Actionable information and advice to help deal with challenges during pregnancy (e.g., tips for saving money for transportation to deliver at a health facility, what is needed for a birthing kit, nutrition information)
- Educational information, including milestones in fetal development, promotion of good health practices, and songs about breastfeeding.

For each week of pregnancy, the pregnant woman receives one primary message and has the option to listen to two additional messages. The messages are tailored to the individual based on her stage

in pregnancy, health care history, location, local system of values and preferences for seeking care and advice.

Given the prevalence of shared phones and the culture of male dominance in Ghana, the majority of messages sent through the *Mobile Midwife* service are designed to be listened to by both the pregnant woman and her family members. MOTECH refers to these users as "pregnant parents". MOTECH has additional tailored messages intended for men only and some intended to be shared more broadly with the community in order to dispel cultural myths and practices (Grameen Foundation, 2012).

All SMS messages delivered as part of the *Mobile Midwife* program are delivered in English. IVR messages are delivered in English or in a few select local languages. For example, during MOTECH's first implementation, two languages – Kasem and Nakam – of the Upper East Region were available as IVR messages. Two additional languages – Senya and Fanta – are supported by the IVR message system in the Awutu Senya District in the Central Region.

A woman registers for the *Mobile Midwife* service through a community nurse or CHW. The health worker asks relevant information about contact and location information (so the patient can be associated with the nearest health facility), demographics, gestational age, phone access (personal or shared), choice of SMS or voice messages, choice of language if voice messages are chosen, and the day and time during the week that is best to receive messages. The nurse enters all information on a MOTECH registration form available on their phone, or by calling and speaking with the MOTECH call center. Upon registration, the patient receives a MOTECH ID number that she uses to retrieve messages (Grameen Foundation, 2012).

The MOTECH system was designed to make its services as widely available and easily accessible to users as possible and was designed to respond to the common act of "flashing" described above. The MOTECH system calls a subscriber back when it receives a "flash" leading them to the IVR system's main menu.

A toll-free short code was developed to enable any woman who does not have access to her own mobile phone or a shared household phone to retrieve her message(s). Women can call a toll-free short code number from any mobile phone using any telecommunications provider. Once connected to the MOTECH service, she is prompted by the IVR system to enter her MOTECH ID, which identifies the client and retrieves her unique message.

Messages are delivered to the woman on the day/time that she chooses during registration. However, it is not uncommon that a woman may miss a message (e.g. being unavailable, dead phone battery, cellular network down, dropped call, etc.). The MOTECH system categorizes any message that has been listened to for less than five seconds as not received and immediately calls the woman back. The system makes three attempts to connect and if those attempts fail, the system calls the woman again the next day at the same time (Grameen Foundation, 2012).

Nurses' Application

The *Nurses' Application* helps community nurses and other community health workers record and track the care being delivered to women and newborns using low-cost GSM mobile phones. Health workers can also use a form in the mobile application to query the database for specific information, such as patients who are overdue for appointments, those overdue for delivery, and those who have recently given birth, an individual's address, and the care that an individual is due for soon. Patient medical records and data is transferred from the phone to a central patient electronic medical records system stored on the MOTECH server.

Results

Mobile Midwife

In the first 26 months since the July 2010 launch, 11,490 members have enrolled in the *Mobile Midwife* program, and 57,921 messages have been delivered to subscribers. Almost all (99%) subscribers chose to receive voice messages rather than SMS and the majority of subscribers were women 21-30 years old. On average, 42% of subscribers who listen to the primary message listen to the secondary message, and 36% listen to the tertiary message (Grameen Foundation, 2012).

In July 2011, one year after MOTECH was launched, Grameen Foundation hired an independent consultant to conduct a qualitative research study to help understand how the system was being used and issues that had arisen. Six discussion groups of six to nine participants each were conducted. Not surprisingly, women who owned their own phones reported no problem accessing their messages. Women who shared a phone with others expressed more difficulty obtaining messages due to travel of others or difficulty navigating the phone to enter the MOTECH ID number. The vast majority of women expressed appreciation for the content of the messages and liked the individualized nature of the messages. The majority of respondents were able to recall specific messages (Grameen Foundation, 2012).

Focus group findings indicated that credibility of the messages was a function of personal experience, rather than where the message came from. *Mobile Midwife* messages are sent to women explaining what will be happening to their bodies during pregnancy and then the women experience those things, thus establishing a foundation of credibility for the messages. It was not important to the women if the messages came from the Ghana Health Service, MOTECH, or a particular clinic.

These messages often provoked behavior change, such as arriving early at the health center for delivery rather than waiting at the house. The discussion groups specifically asked how women changed their behaviors as a result of the messages. The changes mentioned covered the entire span of pregnancy, delivery, and postnatal care. Particularly common were changes in diet for both pregnant women and infants and increased healthcare seeking during pregnancy, delivery, and for the infant after delivery. The majority of women could mention specific ways in which the messages changed their behavior or their family members' behavior.

While the women reported seeing the value of *Mobile Midwife* messages, they reported that paying for these messages would be hard, as they depend on their husbands for money. They said that it is often challenging enough to get money to pay for proper food and transportation to the clinic.

From March through May 2012, interviews were conducted with 30 new *Mobile Midwife* clients each month in the Awutu Senya District in the Central Region to assess their experience. In total, 90 participants were interviewed through random selection from the database. Results confirmed that within focus groups, listening patterns vary significantly based on mobile phone ownership. Forty-three women interviewed experienced difficulty accessing the MOTECH system using IVR, with the most common problems being not knowing the phone number to call to access messages, not knowing the MOTECH ID, and difficulty navigating the IVR system.

Nurses' Application

As of September 2012, 31 facilities and 175 health workers have been involved in the MOTECH initiative. These workers have uploaded 124,446 patient encounters via mobile phone. One of the goals of the MOTECH system is to have automated reports so that health workers do not have to spend time filling out reports by hand. An incentive offered by the Ghana Health System was that nurses who had an 80% accuracy rate entering data with the mobile phone application over 3 consecutive months would no longer be required to produce manual reports. Nurses in 7 of 15 CHPS facilities in the Upper East Region reached this goal. In the Awutu Senya region, workers in 4 of the 12 CHPS facilities reached this goal in just five months.

Recommendations for Utilizing ICT in Demand Generation for RMNCH

The three case studies described present examples of different models for utilizing ICT and new media for increased demand of RMNCH commodities and services. A number of recommendations can be drawn from these case studies to apply lessons learned to future programming in demand generation:

1) **Consider an integrated communication strategy.** ICT and new media are best utilized as part of an integrated strategy for demand generation, one in which mobile applications are complemented by other communication channels such as interpersonal communication, community-based activities, and mass media. One of the strengths of the *Ananya Program* is its "360-degree approach" – in addition to mobile applications targeted at health workers and consumers, the program includes community mobilization and mass media activities. Programs of this nature – comprehensive ones that present an integrated, multi-pronged approach to improve health – are a gold standard for demand generation programming.

2) **Consider multiple ICT and new media services, products, and applications to reach intended audience.** Better access to health information can increase demand for health services. The case studies presented here all included the use of mobile technologies through SMS or IVR messaging. However, multiple ICT and new media services, products, and applications to reach an intended audience can further enhance a program - as seen in *MAMA South Africa* For example, program managers can consider companion products, such as a website and online social networking such as MAMA South Africa's dynamic community portal or mobisite at www.askmama.mobi and MAMA's popular mobile social network, MXit.

3) **Tailor health messages to the individual subscriber.** One of the key benefits of ICT and new media over traditional media is the ability to tailor messaging to meet the specific needs and circumstances of the user. This tailoring was utilized successfully in the case studies to ensure that pregnant women, mothers and health care workers were accessing the most appropriate content for their needs, such as in the subscriber's local language and corresponding to the stage of pregnancy or age of child. In MOTECH's *Mobile Midwife* application, developing and adjusting the content of the messages was possibly the most essential element of the project's overall success.

4) **Involve household decision-makers when appropriate.** In locations where women are not household decision-makers, other family members (often husbands and/or mothers-in-law) act as gatekeepers for many services, including those related to health and technology. Ensuring that the influence of these gatekeepers is acknowledged and addressed in program plans helps ensure that the target population – new and expectant mothers – is able to utilize the family's mobile phone to receive critical health information. For example,

MAMA Bangladesh involved gatekeepers by offering an additional weekly SMS message targeted specifically to husbands and mother-in-laws if they opt-in. In MOTECH, including influencing audiences in programming helped ensure that important messages reached expectant and new mothers.

5) **Position ICT and new media within a broader system, including service delivery.** Mobile phones are a tool that can facilitate more effective solutions to improve demand for RMNCH commodities and services. However, in order for demand generation programs to succeed, program planners need to ensure that the appropriate clinical interventions are in place and available *before* the program is launched. For example, the MOTECH initiative was able to get people to come to a health facility for immunizations. However, having the immunizations in stock and properly refrigerated was challenging.

6) **Plan early for scale-up.** Not all programs should scale-up; however, all programs should plan for potential scale-up during the program design phase to avoid or better manage possible obstacles down the road. Planning and thinking ahead helps with the eventual uptake and adoption of the program on a large scale. The Ananya program's project plan was to initially launch in eight focal districts in Bihar in 2012-2013 and scale-up to the rest of Bihar by 2015. The cost of the Ananya program's comprehensive approach to improving family health will influence future replication and scale-up decisions. Acknowledging this fact during program development, evaluation plans include a cost analysis to generate estimates of overall program costs, the costs of major program components, replication costs, and the key cost drivers. In addition, evaluators – Mathematics Policy Research, Inc. – will attempt to determine the cost-effectiveness of both the program and the value-added solutions, and how cost-effectiveness may have evolved over the course of the Ananya program. Evaluation plans also include a rigorous process evaluation to measure the extent to which scale-up occurred, to understand and document the scale-up process, and to identify factors that facilitated and inhibited scale-up in Bihar.

7) **Plan for sustainability, develop sustainable financing**. Program planners should plan for sustainability during program development. One of MOTECH's goals has been to identify a sustainable business model to support the ongoing operating costs of the service, although program partners are finding this difficult. The population of Ghana is relatively small, and therefore there are a small number of pregnant women who have the capacity and willingness to pay for the *Mobile Midwife* service. Program partners are continually looking for new solutions to making this program self-sustaining.

   The Ananya program identified the government as key stakeholder in providing financing; however, the government first needed evidence of the program's worth and impact as an affordable way to help care for the poor. With the donor agreeing to cover the cost of calls to *Mobile Kunji* for the first year, the government was able to witness the positive response for the service. Recognizing the positive impact that *Mobile Kunji* could have on maternal,

infant, and child health, the government of Bihar agreed to cover health workers' call costs to *Mobile Kunji* on an on-going basis.

8) **Form strategic partnerships**. Leverage the expertise of government, non-profits, and the technology and mobile industry. Engaging key stakeholders early in the process strengthens local ownership as well as the quality and sustainability of the program. For example, one suggested strategic partnership would be with the local mobile network operator(s) who would most likely take on much of the ongoing marketing of the project. It is important to note that relationships with partners often require focused attention and time throughout development, implementation, and program evaluation. Nurses initially viewed MOTECH as a "project" rather than as a new, critical element of their role as an employee of the Ghana Health Service. By involving the Ghana Health Service more visibly in program activities, nurses began to take the work associated with the MOTECH initiative more seriously, which improved data quality and consistency. For more information about public-private partnerships for demand generation, visit the Demand Generation Implementation Kit for Underutilized Commodities in RMNCH (www.sbccimplementationkits.org/demandRMNCH).

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