COMMUNICATIONS SUPPORT FOR HEALTH (CSH) PROGRAMME

SAVING MOTHERS GIVING LIFE (SMGL) EVALUATION STUDY REPORT

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Contents

I. Background on Saving Mothers Giving Life Campaign

1.1. Health Situation Context

Zambia as a nation has made extensive progress in recent years towards achieving the Millennium Development Goals. The Zambian health system continues to improve, and access to services is increasing. However, a number of health issues persist. One critical issue is maternal mortality. Zambia's maternal mortality ratio of 591/100, 000 live births ranks amongst the highest in the world. This mortality is attributable to a number of complex and interwoven factors. Low contraceptive use in Zambia has resulted in high fertility trends over the years, with a current average fertility rate per women of 6.3. Only about half of pregnant women initiate antenatal care (ANC) by 5.1 months of gestation, preventing the opportunity for early detection of danger signs and adequate management of maternal complications. More than half (52 percent) of all births occur at home, with rural areas recording much higher rates of home births than urban areas (66.5 percent as compared to 15.7 percent). But even when a woman delivers in a facility, utilization of postpartum care services is extremely low. Nationwide, more than half (51 percent) of women do not receive any postnatal care. Further, neonatal mortality, while reducing slowly overall, is growing as a proportion of child mortality and is closely aligned with maternal mortality.

1.2. Saving Mothers, Giving Life Initiative Background

To directly address these challenges in maternal mortality, the Government of the Republic of Zambia (GRZ) together with the United States Government committed to providing intensive resources and technical assistance to four targeted districts in Zambia (Mansa, Kalomo, Lundazi, and Nyimba) beginning in 2012. This initiative, termed Saving Mothers Giving Life (SMGL), brings together a wide variety of partners with the goal of reducing maternal mortality by 50 percent in the four districts. The main interventions focus on strengthening the delivery skills of health professionals, increasing delivery in health facilities, mobilizing communities to increase birth preparedness and complication readiness, and strengthening health facilities to provide quality obstetric and newborn care for normal and complicated deliveries.

In order to accomplish this goal, the implementing partners for SMGL are specifically emphasising a set of critical interventions 24 hours immediately before and after delivery. From the demand-creation perspective, two critical behaviours have been identified within this period: (1) pregnant women seek delivery in a facility and (2) pregnant women complete all required postpartum follow-up care within 6 hours, 6 days, and 6 weeks after delivery. As a key partner in the SMGL initiative, the Communications Support for Health (CSH) project will take responsibility for promoting these behaviours and addressing current barriers to their practice.

Specifically, CSH will implement the following main interventions in the four districts:

1. Orientation and distribution of a birth plan tool that can be used by health providers, Safe Motherhood Action Groups (SMAGs), pregnant women, and their male partners.

2. Orientation and training of influential leaders to be "Change Champions" in their communities, with follow-up support as they roll out mobilization activities within their communities.

3. Development, production, and broadcasting of Safe Motherhood radio adverts.

4. Implementation of interpersonal communication activities for pregnant women, young mothers and their male partners, and other key community members that will be conducted by Change Champions and SMAGs.

1.3. Target Audiences for SMGL

The primary target audiences for the proposed CSH SMGL activities include pregnant women and mothers of young children (aged 0–6 months).

There are other target audiences in the campaign, including male partners of pregnant women/mothers, Change Champions, traditional birth attendants/traditional healers, SMAGs, neighbourhood health committees (NHCs), health workers, extended family members, women of child-bearing age who are not currently pregnant (or who recently had a baby), and teenage girls. Due to the main questions of interest in the study as well as the design, these other target audiences, with the exception of the Change Champions, were not included in the study.

II. Evaluation Study

2.1. Objectives of Evaluation

The main objectives of the evaluation were three-fold:

1. To assess the target population's exposure to the SMGL campaign[1] that was designed and implemented by the CSH project in Zambia in collaboration with the Ministry of Community Development and Maternal and Child Health (MCDMCH),

2. To assess the primary target population's perception of the different activities implemented under the SMGL campaign and their perception of whether the SMGL campaign has had an impact on their knowledge and behaviour, and

3. To assess how the Change Champion programme in the four SMGL-targeted districts has worked and what improvements to implementation can be made.

2.2. Specific Evaluation Questions

Table 1 below outlines the specific study questions by the main three study objectives.

[1] For the purpose of the report, all references to the SMGL campaign refer specifically to the communication and demand-creation activities that were implemented by CSH. Since CSH was only one of a number of implementing partners working on SMGL, this report does not provide any information on the other partner activities implemented under the larger SMGL initiative.

Table 1. Specific Study Questions by Study Objective

Study Objective	Specific Study Questions
Objective 1: Determine exposure of target population to SMGL campaign	1. What is the target population's exposure to the following main components of the SMGL campaign? a. Birth plan tool b. Safe Motherhood radio adverts c. Interpersonal communication activity conducted by Change Champions and SMAGs 2. What is the target population's recall of specific messages and characteristics of the main components of the SMGL campaign?
Objective 2: Understand target population's perception of SMGL campaign and perception of the impact of the campaign on knowledge and behaviour	1. What is the target population's perception of the main components of the SMGL campaign? 2. Does the target population find the messages of the campaign relevant to their own lives? 3. Does the target population perceive that the SMGL campaign has had an impact on their knowledge and attitudes/beliefs related to safe motherhood? 4. Does the target population perceive that the SMGL campaign has had an impact on their behaviours related to safe motherhood? If so, which behaviours have they perceived the campaign to have affected?
Objective 3: Determine how the Change Champion programme has worked in the four targeted districts	1. What is the role that the Change Champions perceive they had in their communities? 2. Have the Change Champions been successful in mobilizing their communities around safe motherhood issues? a. If so, how have they mobilized their communities? b. What actions were taken? c. What specific topic areas were they able to mobilize their community around (e.g., ANC, health facility-based delivery, postpartum care, family planning)? d. What changes, if any, have they seen in their communities as a result of the mobilization? 3. What challenges did Change Champions encounter in mobilizing their community around addressing safe motherhood issues? 4. What, if anything, should be done differently as a way of improving the work carried out by Change Champions?

2.3. Evaluation Methodology

The evaluation was a mixed-methods study utilizing a rapid household survey complemented with a qualitative component of in-depth interviews with Change Champions and District Maternal and Child Health (MCH) Coordinators.

The rapid household survey was used to assess the first two main objectives of the study. Specifically, the survey looked at the exposure of the primary target population (pregnant women and mothers of children aged 0–6 months) to the different components of the SMGL campaign; the primary target population's perceptions of the different components of the campaign; and their perceptions as to whether the campaign has had an influence on their knowledge, attitudes/beliefs, and behaviours related to safe motherhood.

In-depth interviews were conducted with Change Champions and District MCH Coordinators who work closely with the Change Champions to complement the findings in the rapid household survey. Specifically, the interviews focused on addressing the third main objective of the study—to assess how the Change Champions programme worked in the four targeted districts and how the programme can be improved upon.

The sampling frame for the rapid household survey is outlined in Table 2. A detailed description of the sampling methodology for the rapid survey can be found in Appendix 1. Informed consent was obtained from each participant prior to conducting the interview.

Table 2. Sampling Frame for the Rapid Household Survey

Province	District	Place of Residence	# of Interviews		
			Pregnant Women	Mothers	Total
Eastern	Lundazi	Rural	19	19	38
Eastern	Nyimba	Rural	19	19	38
Luapula	Mansa	Rural	19	19	38
Southern	Kalomo	Rural	19	19	38
Total			**76**	**76**	**152**

For the in-depth interviews, a total of 24 Change Champions and four MCH Coordinators were initially selected to be interviewed. In each of the four targeted districts, five Change Champions were randomly selected to be included in the study sample. In addition, the MCH Coordinator in each of the target districts was invited to be interviewed. The sampling frame for the in-depth interviews is provided in Table 3 below.

Table 3. Sampling Frame for In-Depth Interviews

District	District MCH Coordinator	Chiefs	Other Change Champions	Total # of Sampled Participants
Mansa	1	1	4	6
Kalomo	1	1*	4	6
Lundazi	1	1	4	6
Nyimba	1	1	4	6
Total	**4**	**4***	**16**	**24**

*A Chief from Kalomo was not available for the interview, resulting in a total of three Chiefs participating in the evaluation, for a total of 23 in-depth interviews.

2.4. Evaluation Study Implementation

CSH developed the study protocol, including the methodology and instruments, and it was reviewed and approved by GRZ through the National HIV/AIDS/TB Council. Ethical approval was obtained from a local ethics review board (ERES Converge) and ICF International's Institutional Review Board in the United States.

The survey questionnaire consisted of the following sections[2]:

1. Sociodemographic characteristics;
2. General exposure to the campaign and source of exposure;
3. Exposure to the birth plan and use and perceptions of the birth plan;
4. Exposure to and perceptions of Safe Motherhood radio adverts; and
5. Perception of the impact of the campaign on knowledge, attitudes/beliefs, and behaviours, and discussion of the campaign messages with others.

The questions included a combination of spontaneous recall questions and aided questions for measuring exposure to the different components of the campaign. Both types of questions were included in order to obtain a more accurate measure of exposure; with aided questions, there is a likelihood that respondents will overreport their exposure, whilst for spontaneous recall questions it is likely that respondents will underreport their exposure.[i] Furthermore, spontaneous recall questions are able to better measure the quality of exposure, as they show that respondents can recall specific elements of what they were exposed to; for example, recalling the message of an announcement heard on the radio. The survey questionnaire tool used can be found in Appendix 2.

To prepare for deployment of the rapid survey, CSH conducted a pilot-testing of the questionnaire and also translated the survey questionnaire into two local languages (Bemba and Nyanja). The

[2] The survey questionnaire initially included questions to assess television media use and exposure; however, the data are not included in this report due to an adjustment in the implementation.

translations were reviewed and approved by the CSH technical and monitoring and evaluation (M&E) team. The CSH M&E team conducted a 1-day training for the field interviewers. Three interview teams, consisting of one supervisor and three interviewers, carried out data collection in the four districts over the course of 8 days. Supervisors were responsible for coordinating the logistics, overseeing interviewers, and checking the questionnaires upon completion of interviews. On average, interviews took 12–20 minutes to conduct.

2.5. SMGL Campaign Implementation

For this rapid survey component of the evaluation, the focus was to assess exposure to the different SMGL campaign components that were implemented 6 months prior to the survey. For the 6-month time period, the main components implemented included the distribution of a pictorial birth plan by health providers and SMAG members, radio adverts on safe motherhood, and the implementation of the Change Champions programme. For the Change Champions programme, CSH provided the selected Change Champions with an initial orientation on the programme approach and information on the six steps to safe motherhood (using the birth plan as a reference). The programme strategy included having Change Champions collaborate with the District Health Officers (DHOs), health workers, and other community-based organisations, such as SMAGs, NHCs, and others in their districts, to implement the activities. Across the four districts, 89 Change Champions were oriented and selected to be a part of the programme. The main roles of the Change Champions were to mobilize, sensitize, and educate their communities on the steps to safe motherhood, with the aim of creating demand for health services amongst pregnant women and new mothers, and to encourage families to provide support to women during their pregnancy, during labour, and after delivery. It is important to note that, in addition to the initial orientation for the Change Champions, CSH identified the need for further training, and then provided additional mentoring to the Change Champions, particularly to those who felt they needed additional support.

A summary of what was implemented 6 months prior to the survey can be found in Table 4.

Table 4. Summary of the Implementation of the SMGL's Different Components 6 Months Prior to Evaluation

SMGL Campaign Component	Channel(s) Used	Frequency	Total Number of Times Aired/ Distributed	Duration
Pictorial Birth Plan	Health facility personnel and SMAGs	Distributed at first ANC visit, outreach activities and home visits	Ongoing	June 2012–present
Radio Adverts (English Version)	National radio stations, Radio 2 and Radio 4 Multiple	Each of the six versions aired once a day during primetime	Aired a total of 8,534 times	December 2012–October 2013

	community radio stations (only Lundazi district covered)			
Radio Adverts (Local Languages, Nyanja and Bemba)	National radio, Radio 1 Multiple community radio stations (covering Manda and Lundazi districts)	Each of the six versions of the advert aired once a day during primetime	Aired a total of 630 times	June–October 2013
Radio Adverts (District Specific)	Yangeni and Chikaya community radio stations (covering Mansa and Lundazi districts)	Once a day during primetime	Aired a total of 180 times (90 per each station)	June–October 2013
Change Champions Programme	Change Champions and the four DHOs engaged	Frequency of implementation of activities varied across Change Champions	89 Change Champions oriented and engaged in programme	Orientation: August–September 2012 Mentorship programme: May–November 2013 Implementation of programme: September 2013–present

III. Findings From Household Survey

This section contains the findings from the household rapid study. The rapid household survey data addressed the first and second study objectives, which focus on assessing the exposure of the target population to the SMGL campaign and assessing the target population's perception of the SMGL campaign and perception of the impact of the campaign on the target population's knowledge, attitudes/beliefs, and behaviour. Section four of the report focuses on the findings from the in-depth interviews, which assessed the third study objective.

For the household rapid survey, frequency analysis was used for all of the variables in the survey and was complemented with Fisher's exact test to assess if there were any significant differences by target audience (pregnant women and mothers of children aged 0–6 months) and district. The majority of the results for exposure, recall of specific content of the campaign components, and perception of impact are presented for the entire sample (152), by district and target audience. When appropriate and as indicated, results are presented amongst other subsamples.

3.1. Sociodemographic Characteristics of the Sample

A summary of the sociodemographic characteristics of the household survey sample can be found in Table 5. The majority of the women were between the ages of 20 and 29 years (54.6 percent) and

had either a primary (49.3 percent) or secondary (38.2 percent) level of education. About 70 percent of respondents were literate in English, a local language, or both, and just under a third of the respondents were illiterate. The majority of respondents (89.5 percent) were married. Pregnant women and mothers of children aged 0–6 months were similar across the different sociodemographic characteristics. Amongst the women who were pregnant, 9.2 percent were in their first trimester, 32.9 percent were in their second trimester, and 57.9 percent were in the third trimester of their pregnancy. Amongst the mothers, the mean age of their children was 2.5 months.

Table 5. Sociodemographic Characteristics of Sample

Sociodemographic Characteristics	Pregnant Women (n=76)	Mothers of Children Aged 0–6 Months (n=76)	Total (n=152)
Age Group			
15–19	18.4	14.5	16.5
20–24	31.6	29.0	30.3
25–29	21.1	27.6	24.3
30–34	13.2	17.1	15.1
35–39	15.8	11,8	13.8
Education Level			
None	9.2	13.2	11.2
Primary	46.1	52.6	49.3
Secondary	44.7	31.6	38.2
Higher	0.0	2.6	1.3
Literacy			
Literate	67.1	73.4	69.7
Illiterate	32.9	27.6	30.3
Marital Status			
Single	7.9	9.2	8.6
Married	92.1	86.8	89.5
Widowed/Separated	0.0	4.0	2.0

3.2. Access to and Use of Media

Overall, access to radio and mobile phones in respondents' households was high: 61.8 percent had a radio and 67.8 percent had a phone (Table 6). Radio and mobile phone ownership did not vary significantly across the four districts.

Table 6. Target Audience Access to Media in the Household by District (n=152)

Sociodemographic Characteristics	Radio (%)	Mobile Phone (%)
District		
Kalomo	65.8	79.0
Lundazi	63.2	55.3
Mansa	73.7	71.1
Nyimba	44.7	65.8
Total	**61.8**	**67.8**

Radio Listenership

The survey looked at overall listenership of radio, in addition to the frequency of listenership, the time periods that are most listened to, and the most listened-to radio stations, to provide information to lead media planning efforts.

Overall, 65.1 percent of respondents reported that they listen to the radio (Table 7). Listenership of radio varied significantly by district, with the highest listenership in Lundazi and Mansa districts, but did not vary significantly by target audience.

Table 7. Radio Listenership by District and Target Audience (n=152)

Sociodemographic Characteristics	Listen to Radio (%)
*District**	
Kalomo	63.2
Lundazi	79.0
Mansa	71.1
Nyimba	47.4
Target Audience	
Pregnant Women	64.5
Mothers of Children Aged 0–6 Months	65.8
Total	**65.1**

* Radio listenership varied significantly by district (p=0.03).

Of all respondents, about 35 percent reported listening to the radio on a daily basis, followed by 15 percent who reported listening 2–3 times per week (Table 8). About 35 percent of respondents reported that they do not listen to the radio.

Table 8. Frequency of Radio Listenership (n=152)

Sociodemographic Characteristics	Frequency of Listenership				
	Daily	4–5 Times per Week	2–3 Times per Week	Once a Week*	Not at All
District					
Kalomo	31.6	5.3	18.4	5.3	36.8
Lundazi	39.5	2.6	13.2	23.7	21.1
Mansa	36.8	10.5	23.7	0.0	29.0
Nyimba	31.6	5.3	5.3	5.3	52.6
Total	**34.9**	**5.9**	**15.1**	**8.6**	**34.9**

*p≤ 0.01

For the most listened-to time periods during the day (Table 9), respondents reported that they listen to the radio most during the following three time periods: 18:00 p.m. to 21:00 p.m. (36.8 percent), 6:00 a.m. to 9:00 a.m. (21.7 percent), and 15:00 p.m. to 18:00 p.m. (21.1 percent).

Table 9. Most Listened-to Time Periods for Radio by District (n=152)

District	Time Period						
	1:00 to 6:00 %	6:00 to 9:00 %	9:00 to 12:00 %	12:00 to 15:00 %	15:00 to 18:00 %	18:00 to 21:00 %	21:00 to 24:00* %
District							
Kalomo	0.0	23.7	13.2	15.8	13.2	34.2	2.6
Lundazi	0.0	29.0	26.3	31.6	34.2	50.0	2.6
Mansa	2.6	21.1	15.8	13.2	21.1	34.2	21.1
Nyimba	10.5	13.2	10.5	18.4	15.8	29.0	2.6
Total	**3.3**	**21.7**	**16.5**	**19.7**	**21.1**	**36.8**	**7.2**

*p ≤ 0.01

Amongst all respondents, the most listened-to radio stations were Radio 1 (31.6 percent), Radio 2 (17.1 percent) and Radio Chikaya (17.1 percent). The top three most listened-to radio stations for each district and overall are highlighted (shaded in boxes) in Table 10 below.

Table 10. Most Listened-to Radio Stations (n=152)

Station	District (%)				
	Kalomo	Lundazi	Mansa	Nyimba	Total
Radio					
Radio 1	21.1	23.7	44.7	36.8	**31.6**
Radio 2*	2.6	23.7	34.2	7.9	**17.1**
Chikaya*	0.0	68.4	0.0	0.0	**17.1**
Yangeni Radio*	0.0	5.3	57.9	0.0	**15.8**
Namwianga*	52.6	0.0	0.0	0.0	**13.2**
Breeze FM*	0.0	31.6	0.0	13.2	**11.2**
K FM*	0.0	2.6	26.3	0.0	**7.2**
Tigabane	0.0	15.8	0.0	0.0	**4.0**
Petauke	0.0	0.0	0.0	13.2	**3.3**
Radio Maria	0.0	10.5	0.0	2.6	**3.3**
Macha	7.9	0.0	0.0	0.0	**2.0**

* $p \leq 0.001$

3.3. General Exposure to SMGL Campaign

In this section of the survey, general exposure to the campaign was assessed by whether respondents had heard about the SMGL campaign and, if so, from what source they had heard about it.

Overall, 47 percent of respondents recalled hearing of the SMGL campaign.[3] This included 24 percent who recalled the campaign spontaneously, and 24 percent who recalled the campaign when prompted by the interviewer. Total recall of the campaign was slightly higher amongst mothers of children aged 0–6 months (51.3 percent) compared to pregnant women (43.4 percent). In addition, total recall of the campaign varied significantly by district and literacy. Recall of the campaign was much higher in Kalomo (60.5 percent) and Mansa (52.6 percent) than in Lundazi (29.0 percent). Similarly, total recall of the campaign was higher in literate respondents (51.9 percent) compared to illiterate respondents (37 percent). Spontaneous, prompted, and total recall of the campaign by all sociodemographic characteristics can be found in Table 11.

[3] All references to the SMGL campaign are inclusive of the Mothers Alive campaign, as the campaign names were used interchangeably in the four districts. For the report, we are using the term SMGL to also encompass Mothers Alive.

Table 11. Percentage of Respondents Who Had Heard of SMGL Campaign by Sociodemographic Characteristics (n=152)

Sociodemographic Characteristics	Spontaneous Recall of Campaign (%)	Prompted Recall of Campaign (%)	Total Recall of Campaign* (%)
Target Audience			
Pregnant Women	19.4	23.7	43.4
Mothers of Children Aged 0–6 Months	27.6	23.7	51.3
District			
Kalomo	36.8	23.7	60.5
Lundazi	10.5	18.4	29.0
Mansa	23.7	29.0	52.6
Nyimba	23.7	23.7	47.4
Age Group			
15–19	16.0	20.0	36.0
20–24	21.7	28.3	50.0
25–29	24.3	18.9	43.2
30–34	39.1	8.7	47.8
35–39	19.1	42.9	61.9
Education Level			
None	29.4	29.4	58.8
Primary	18.7	18.7	37.3
Secondary	29.3	27.6	56.9
Higher	0.0	50.0	50.0
Literacy			
Literate (English, local language, or both)	26.4	25.5	51.9
Illiterate	17.4	19.6	37.0
Marital Status			
Single	15.4	38.5	53.9
Married	25.0	22.1	47.0
Separated or Widowed	0.0	33.3	33.3
Total	**23.7**	**23.7**	**47.4**

* For total recall of the campaign, the results varied significantly by district ($p \leq 0.05$) and literacy ($p \leq 0.05$).

When respondents were asked from where they had heard, read, or seen anything about the SMGL campaign, just under one third of respondents (28 percent) reported having heard of the campaign at a health facility (Table 12). The second and third most reported sources of their exposure to the campaign were through print materials (14 percent) and via the radio (9 percent). Exposure to the

campaign via print materials, radio, and health facilities varied by district. For example, about 42 percent of respondents in Kalomo reported having heard of the campaign through print materials, while no respondents in Lundazi reported being exposed to the campaign via print materials.

Table 12. Source of Exposure to Campaign by District (n=152)

District	Source of Exposure (%)							
	Health Facility**	Print Material***	Radio*	Community Activity	Friend/ Family	SMAG	T-shirt/ chitenge	Induna
Kalomo	50.0	42.1	7.9	2.6	0.0	5.3	0.0	2.6
Lundazi	15.8	0.0	2.6	10.5	1.6	0.0	0.0	0.0
Mansa	15.8	10.5	23.7	0.0	5.3	0.0	2.6	0.0
Nyimba	29.0	2.6	2.6	2.6	0.0	0.0	2.6	0.0
Total	**27.6**	**13.8**	**9.2**	**4.0**	**2.0**	**1.3**	**1.3**	**0.7**

* p≤0.05
** p≤0.01
*** p≤0.001

3.4. Exposure to Birth Plan

In this section, the survey assessed the target audience's exposure to the pictorial birth plan, the timing and location of when they received the birth plan, their spontaneous recall of the topics/messages presented in the birth plan, how respondents used the birth plan and their overall perceptions of the birth plan.

Exposure to Birth Plan

Overall, just over 70 percent of respondents recalled having seen the birth plan (Table 13). Of these, 61 percent recalled the birth plan spontaneously, while another 10.5 percent recalled having seen the birth plan when prompted by the interviewer. Total recall of the birth plan varied significantly by target audience, with overall recall amongst mothers of children aged 0–6 months at 80 percent, and only 62 percent amongst women who are currently pregnant. Recall by district also varied significantly, with higher recall in Nyimba, Mansa, and Kalomo districts, and lower recall in Lundazi district.

Table 13. Exposure to Birth Plan (n=152)

Sociodemographic Characteristics	Spontaneously Recalled Birth Plan* (%)	Recalled Birth Plan When Prompted** (%)	Total Who Recalled Birth Plan*** (%)
Target Audience			
Pregnant Women	50.0	13.2	61.8
Mothers of Children Aged 0–6 Months	72.4	7.9	80.2
District			
Kalomo	57.9	18.4	76.3
Lundazi	50.0	5.3	52.6
Mansa	76.3	0.0	76.3
Nyimba	60.5	18.4	79.0
Total	**61.2**	**10.5**	**71.1**

* For spontaneous recall of the birth plan, the results varied significantly by the target audience ($p \leq 0.01$).
** For prompted recall of the birth plan, the results varied significantly by district ($p \leq 0.01$).
*** For total recall of the birth plan, the results varied significantly by target audience ($p \leq 0.05$) and district ($p \leq 0.05$).

Timing and Location of Receipt of Birth Plan

Of all respondents, 47.4 percent reported having received their own copy of the birth plan. This varied significantly by target audience, with 60.5 percent of mothers with children aged 0–6 months reporting that they received the birth plan, while only 34 percent of currently pregnant women received a copy. Receipt of the birth plan also varied by district, with 63.2 percent of respondents in Nyimba district reporting that they received their own copy, while only 39.5 percent of respondents received it in the Lundazi and Kalomo districts.

Of those who received the birth plan, the majority of respondents (86.1 percent) reported that they received it from a health worker at a health facility. This did not vary by target audience but did vary significantly by district, with 100 percent of women reporting they received it from a health worker in Nyimba and Kalomo, 86.7 percent of women in Lundazi, and only 55.6 percent in Mansa. Interestingly, in Mansa, 44.4 percent of women reported that they received the birth plan from a SMAG member, while overall, only 16.7 percent of all respondents reported that they received it from a SMAG member. Of those who received the birth plan (n=108), just over 80 percent of women reported that someone did explain the birth plan to them. This varied significantly by district, with almost all women in Nyimba (96.7 percent) stating that someone explained the birth plan to them, compared to only 65.6 percent of women in Mansa. It was most common for a health worker at a health facility to explain the birth plan to the women (78.4 percent), compared to a SMAG member (22.7 percent). However, this varied significantly by district, with many more women in Mansa reporting that a SMAG member explained the birth plan to them (57.9 percent), compared to only 10.3 percent of women in Nyimba.

When asked the timing of when the women received the birth plan, the majority received it 4–6 months into their pregnancy (62.5 percent), 20.8 percent received it during months 7–9, and only 16.7 percent received it during the first 3 months of their pregnancy. The timing of when women received the birth plan did not vary significantly by target audience or district of residence.

Recall of Topics in Birth Plan

Of all respondents, 66.5 percent were able to spontaneously recall at least one topic or message from the birth plan. Just over a quarter of respondents (27 percent) were able to recall two messages from the birth plan, while 22.4 percent recalled three messages and about 10 percent of respondents recalled four or five different messages on the birth plan.

The most recalled messages from the birth plan were topics presented in the education, logistics, and nutrition and care sections of the plan (Table 14). Amongst all respondents, 54.6 percent recalled information presented in the education section of the birth plan, 35.5 percent from the logistics section, and 33.6 percent from the nutrition and care section.

Table 14. Spontaneous Recall of Topics/Messages Presented in the Birth Plan

Topic/Message	Respondents Who Were Exposed to Birth Plan (n=108)	All Respondents (n=152)
Education (information on due date, labour signs, danger signs, breastfeeding, and/or care for the baby)	76.9	54.6
Logistics (information on saving for transport and supplies for delivery)	50.0	35.5
Nutrition and care (information on a healthy diet, vitamin and mineral supplementation)	47.2	33.6
ANC and postnatal visits (information on timing and number of visits)	27.8	19.7
Social support (information on importance of support from family and/or partner or husband)	13.9	9.9
Importance of resting during pregnancy*	6.5	3.6
Malaria prevention during pregnancy	4.6	3.3
Importance of health facility delivery	4.6	3.3
Information on family planning	3.7	2.6
Prevention of mother-to-child transmission (PMTCT)*	1.9	1.3

*These specific messages were not part of the birth plan; however they likely were included in the counselling provided to pregnant women by health workers or SMAGs.

Use of Birth Plan

Amongst respondents who were exposed to the birth plan, when asked how they used the birth plan, the most common use of the birth plan was to learn about danger signs during pregnancy, delivery, and postpartum (Table 15). Other commonly reported uses included preparing logistics

(48.2 percent), saving money (43.5 percent), and learning about facility-based delivery (40.7 percent). A total of 17.6 percent of respondents who had been exposed to the birth plan reported that they did not use it.

Table 15. How Respondents Used the Birth Plan (n=108)

Use	%
Learning about danger signs	50.9
Preparing logistics	48.2
Saving money	43.5
Learning about facility-based delivery	40.7
Learning about how to care for a baby	21.3
Learning about services provided at ANC visits	13.9
Eating healthy	10.2
Learning about partner/family involvement	2.8
Exercising/resting during pregnancy*	1.9

*This specific use and message was not part of the birth plan; however, it was likely included in the counselling provided to pregnant women by health workers or SMAGs.

Perceptions of the Birth Plan

Overall, respondents perceived the birth plan to be easy to use and useful (Table 16). More than 82 percent of respondents either agreed or strongly agreed with the statement "I find the birth plan easy to use." Similarly, almost 98 percent of respondents agreed or strongly agreed with the statement "I find the birth plan useful." The majority of respondents also either agreed or strongly agreed that the birth plan was helpful in preparing for childbirth, that they follow/followed the monthly birth planning steps in the birth plan, and that they would recommend the birth plan to a family member or friend.

Table 16. Respondents' Perceptions of Birth Plan

Statement (n)	Agreement With Statement (%)				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I find the birth plan easy to use. (n=86)	9.3	8.1	0.0	26.7	55.8
I find the birth plan useful. (n=87)	1.2	1.2	0.0	41.4	56.3
The birth plan helps/helped me during my pregnancy to prepare for childbirth.* (n=88)	1.1	3.4	34.1	34.1	61.4
I follow/followed the monthly birth planning steps presented on the birth plan. (n=87)	1.2	5.8	13.8	44.8	34.5

Statement (n)	Agreement With Statement (%)				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I would recommend the birth plan to a family member or friend. (n=87)	0.0	4.6	1.2	28.7	65.5

* For this statement, results varied significantly by target audience (p=.05).

3.5. Exposure to Radio Adverts

In this section, the survey assessed the target audience's exposure to the Safe Motherhood radio adverts, their recall of the main topics and messages in the adverts, and their perceptions of the adverts.

Exposure to Safe Motherhood Radio Adverts

Of all respondents, about 20 percent recalled having heard of the Safe Motherhood radio adverts (Table 17). This varied significantly by district, with the highest recall of the radio adverts in Mansa (34.2 percent) and the lowest in Nyimba (7.9 percent). This is likely due to greater coverage of the radio adverts in Mansa and Lundazi districts, which included both national- and community-level radio stations. In Nyimba district, radio adverts were only aired on national-level radio stations. Recall of the radio adverts did not vary significantly by target audience but was slightly higher amongst mothers of children aged 0–6 months than pregnant women.

Table 17. Recall of Safe Motherhood Radio Adverts (n=152)

District	Pregnant Women Recalled Advert (%)	Mothers of Children Aged 0–6 Months Recalled Advert (%)	Total Who Recalled Advert (%)*
Kalomo	26.3	10.5	18.4
Lundazi	10.5	26.3	18.4
Mansa	31.6	36.8	34.2
Nyimba	0.0	15.8	7.9
Total	**17.1**	**22.4**	**19.7**

*Total recall of the radio advert varied significantly by district (p≤0.05).

Recall of the Safe Motherhood radio adverts amongst only the respondents who had access to a radio in the household was 29.8 percent (n=94). Similarly, recall amongst respondents with access to a radio was highest in Mansa at 42.9 percent and lowest in Nyimba district at 17.8 percent, and slightly higher amongst mothers of children aged 0–6 months (34 percent) than pregnant women (25.5 percent).

Recall of Radio Station for Safe Motherhood Adverts

When respondents were asked what radio station they heard the advert on, the most commonly reported stations were Radio Yangeni (23.3 percent), Radio 1 (20 percent), and Radio Numwianga (16.7 percent). A few others mentioned K FM and Radio Chikaya stations (10 percent each). Recall of the community stations that aired the adverts varied significantly by district, which was expected since coverage of the different radio stations varied by district. For example, 53.9 percent of respondents in Mansa district recalled hearing the advert on Radio Yangeni, while none of the respondents from the other districts recalled hearing the advert on the station. Recall of the adverts on the national-level radio station 1 did not vary by district.

Spontaneous Recall of Topics/Messages in Safe Motherhood Radio Adverts

Of all respondents, 17.8 percent were able to spontaneously recall at least one topic or message presented in the radio adverts. Amongst only those who recalled the radio advert (n=30), 90 percent reported recalling at least one topic or message from the advert, 20 percent recalled one message from the adverts, more than 40 percent recalled two messages, and 30 percent recalled three to five different messages from the adverts.

The most commonly recalled topics or messages from the radio adverts were saving money during pregnancy; the importance of delivering in a health facility; and the danger signs to watch for during pregnancy, delivery, and/or postpartum (Table 18).

Table 18. Spontaneous Recall of Topics/Messages Presented in the Safe Motherhood Radio Adverts

Topic/Message	Respondents Who Saw the Advert (n=30)	All Respondents (n=152)
Saving money	40.0	7.9
Importance of facility-based delivery	40.0	7.9
Danger signs during pregnancy, delivery, and/or postpartum	33.3	6.6
Attending ANC early	30.0	5.9
Family planning	20.0	4.0
Healthy diet	16.7	3.3
Importance of resting/doing light work during pregnancy	10.0	2.0
How to care for child after delivery	10.0	2.0

Perception of Safe Motherhood Radio Adverts

Overall amongst the respondents who recalled hearing the safe motherhood radio adverts, the majority reported understanding the messages presented in the adverts and felt that the adverts

contained important information that was relevant to them (Table 19). For example, when respondents were asked if the information in the radio advert is important for women who are pregnant and their partners, 85 percent of respondents strongly agreed.

Table 19. Perception of Safe Motherhood Radio Adverts (n=27)

Statements	Agreement With Statement (%)				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I understood the messages in the radio advert/spot.	0.0	0.0	0.0	44.4	55.6
I found the message in the radio spot/advert more compelling since it was communicated by a chief.	0.0	3.7	3.7	25.9	66.7
I think it is important to follow what the chief was saying in the advert/radio spot.	0.0	0.0	0.0	37.0	63.0
The radio spot made me seriously think about how to achieve better health for me and my baby during and after my pregnancy.	0.0	0.0	3.7	37.0	59.3
The information in the radio advert/spot is important for women who are pregnant and their partners.	0.0	0.0	3.7	11.1	85.2

3.6. Summary of Exposure to Components of the SMGL Campaign

Table 20 below provides a summary of the respondents' exposure to the various components of the SMGL campaign. Overall recall of the SMGL campaign was just under 50 percent. The most commonly recalled component of the campaign was the birth plan, with more than 70 percent of respondents reporting that they had seen the birth plan. Overall, 77 percent of respondents reported having recalled at least one of the main components of the campaign (birth plan, radio adverts, and/or interaction with a Change Champion in their community).

Table 20. Summary of Target Population's Exposure to the Various Components of the SMGL Campaign (n=152)

Components of the SMGL Campaign Recalled	Exposure (%)
General Exposure to Campaign	
Heard of SMGL campaign	47.4
Exposure to Birth Plan	
Recalled birth plan	71.1

Exposure to Radio Adverts	
Recalled Safe Motherhood radio adverts	19.7
Spontaneously recalled radio advert topics/messages	17.8
Exposure to SMGL Campaign by Media Channel	
Radio	19.7
Print product (birth plan)	71.1
Exposure to at Least One SMGL Campaign Component	
At least one SMGL campaign component*	77.0

* Refers to exposure to at least one of the following campaign components: the birth plan, the radio adverts, and/or interaction with a Change Champion in the respondent's community.

3.7. Perception of Impact on Knowledge, Attitudes, and Behaviour

This section presents findings related to the audience's perception of the impact of the SMGL campaign on their knowledge, attitudes/beliefs, and behaviour. Examining perception of impact is helpful because it provides an indication of whether the population perceives an effect and, if so, on which specific areas of their knowledge, attitudes, and behaviours. Findings showing that the audience perceives an impact are encouraging and indicate that the messages are having an effect.[4] However, it is important to note that perception of impact results is not an actual true estimate of impact and is only a crude measure, highly subject to social desirability bias. This means that the results should not be interpreted as the effect size of the campaign. To measure the actual impact of a campaign, the knowledge, attitudes, and reported behaviours of those exposed to the campaign have to be compared with those who are unexposed, and this can only be done through a large representative survey conducted specifically for this purpose.

Perception of Impact on Respondents' Knowledge and Attitudes/Beliefs

When respondents were asked if they had learnt anything from the Safe Motherhood messages that they had heard, seen, or read, 82.9 percent responded that they had. Amongst the respondents who were able to recall at least one specific component of the SMGL campaign (n=117), 91.6 percent reported that they had learnt something from campaign. It is important to note that when compared to those who had recalled at least one main component of the campaign (77 percent, Table 23), the number of respondents reporting that they learnt something from the campaign was slightly lower. This is likely due to over-reporting amongst respondents about what they learnt from the campaign.

The most commonly recalled information and knowledge from the campaign amongst the respondents was the importance of saving money, danger signs, the importance of seeking care at their onset, the importance of facility-based delivery, and the importance of attending ANC early (Table 21).

[4] Perception of impact results is always presented for the whole target audience and not just for those exposed and those who answered the questions about impact.

Table 21. Knowledge Learnt From SMGL Campaign

Knowledge Learnt	% of Respondents' Reporting Exposure to the SMGL Campaign (n=117)	% Amongst All Respondents (n=152)
Importance of saving money	63.3	55.3
Danger signs and importance of seeking care at their onset	64.1	54.0
Importance of facility-based delivery	52.1	46.7
Importance of attending ANC early	36.8	32.2
Mother/baby care after pregnancy	11.1	9.2
Family planning	9.4	7.2
Vitamin supplementation during pregnancy	6.8	6.6
Importance of HIV/sexually transmitted infection (STI) testing	5.1	4.6
Use of insecticide-treated nets (ITNs) for malaria prevention during pregnancy	2.6	4.0
Hygiene	4.3	3.3
PMTCT	1.7	1.3

Of the respondents who were able to recall at least one component of the SMGL campaign, 89.7 percent were able to recall at least one topic or message that they learnt from the campaign. Of these, 56.4 percent recalled two or three topics/messages and 23.1 percent were able to recall four or more topics/messages that they learnt from the campaign.

Respondents were asked whether they agreed or disagreed with a number of statements regarding their knowledge and attitudes/beliefs on safe motherhood. Table 22 below summarises the respondent's agreement/disagreement with the 10 statements. Overall knowledge around safe motherhood was high, and respondents exhibited ideal attitudes and beliefs on the various safe motherhood topics. For example, the majority of respondents (98.5 percent) either strongly agreed or agreed with the statement "It is beneficial for the mom and baby's health to attend antenatal care early in pregnancy." Similarly all respondents either strongly agreed or agreed with the statement "I believe that delivering from a health facility is safer than delivering a baby at home."

Overall, respondents also felt that the messages in the SMGL campaign were relevant for women in their community, with 70.6 percent of respondents stating that they strongly agreed and 29.4 percent stating that they agree that the messages were relevant.

Table 22. Agreement With Safe Motherhood Knowledge and Attitude Statements (n=126)

Statements	Agreement With Statement (%)				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I fear that when I go for ANC I will be tested for HIV.	75.4	17.5	0.0	4.0	3.2
It is beneficial for the mom and baby's health to attend ANC early in a pregnancy.	0.0	0.0	1.6	18.3	80.2
I do not fear the process or experience of delivering a baby in a health facility.	4.0	3.2	0.0	27.8	65.1
I believe that delivering from a health facility is safer than delivering a baby at home.	0.0	0.0	0.0	17.5	82.5
The safe motherhood programme made it easier to get support from my family during pregnancy and childbirth.	0.0	7.1	11.1	42.1	39.7
I am aware of the danger signs during pregnancy/labour/ postpartum.	1.6	3.2	10.3	31.0	54.0
I am aware of the various safe motherhood services provided by health facilities.	0.8	7.1	16.7	41.3	34.1
I believe that the quality of care and treatment at the health facility in my community is adequate.	1.6	2.4	12.0	27.2	56.8
I believe that it is beneficial/ important to plan for childbirth when one is pregnant.	0.8	0.8	1.6	23.8	73.0
The messages in the Safe Motherhood programme are relevant for women in my community.	0.0	0.0	0.0	29.4	70.6

Perception of Impact on Respondents' Behaviour

Amongst all respondents, 72.4 percent reported that the SMGL campaign had an impact on their behaviour. Of only the respondents who were able to recall at least one specific component of the campaign (n=117), 82.4 percent reported that the campaign influenced their behaviour.

The most commonly reported influences on respondents' behaviours amongst the respondents were that they saved money while pregnant, attended ANC early in their pregnancy, and delivered or planned to deliver in a health facility (Table 23).

Table 23. SMGL Campaign Influence of Respondents' Behaviours

Behaviour	% of Respondents' Reporting Exposure to the SMGL Campaign (n=117)	% Amongst All Respondents (n=152)
Saved money	47.0	40.8
Attended ANC early	35.0	29.0
Delivered in a health facility or plan to deliver in a health facility	32.5	28.3
Sought care for danger signs	30.8	25.7
Improved diet	23.9	19.7
Involved family in preparing for logistics	12.8	11.2
Attended postnatal care or plan to attend postnatal care	7.7	7.2
Improved breastfeeding practices or plan to improve breastfeeding practices	6.0	5.3
Improved duration of rest during pregnancy	4.3	4.0
Used an ITN	3.4	4.0
Went for an HIV test	4.3	3.3
Started family planning	1.7	1.3
Took vitamin supplementation	1.7	1.3

3.8. Interpersonal Communication

Interpersonal Communication With Health Workers and Change Champions

When respondents were asked if anyone had discussed safe motherhood with them in the past 6 months, a total of 69.7 percent responded "yes." The majority of respondents reported having discussed safe motherhood with a health worker (48.7 percent) or a SMAG member (30.9 percent). Of all respondents, 14.5 percent either spontaneously recalled or recalled when prompted by the interviewer that they had discussed safe motherhood with a Change Champion (Table 24). Recall of having a discussion on safe motherhood with a Change Champion did not vary significantly by district but was slightly higher in Mansa (18.4 percent) than in Kalomo (10.5 percent).

Table 24. Recall of Safe Motherhood Discussion With Change Champions (n=152)

District	Spontaneously Recalled Safe Motherhood Discussion With Change Champion (%)	Recalled, When prompted, Safe Motherhood Discussion With Change Champion (%)	Total Who Recalled Safe Motherhood Discussion With Change Champion (%)
Kalomo	2.6	7.9	10.5
Lundazi	7.9	7.9	15.8
Mansa	2.6	15.8	18.4
Nyimba	7.9	5.3	13.2
Total	**5.3**	**9.2**	**14.5**

Spontaneous Recall of Topics Discussed With Change Champions

Amongst respondents who reported discussing safe motherhood issues with a Change Champion, the most common spontaneously recalled topics that were discussed included the need to save money during pregnancy; the importance of attending ANC early in pregnancy; importance of facility-based delivery; and danger signs during pregnancy, delivery, and postpartum, and the importance of seeking care at their onset (Table 25).

Table 25. Spontaneous Recall of Topics Discussed With Change Champions

Topics/Messages	Respondents Who Recalled Discussion With Change Champion (n=22)	All Respondents (n=152)
Save money	57.9	7.2
Importance of attending ANC early	57.9	7.2
Importance of facility-based delivery	52.6	6.6
Danger signs and importance of seeking care at their onset	47.4	5.9
Healthy eating	10.5	1.3
Family planning and birth spacing	5.3	0.6
Importance of postnatal care	5.3	0.6
PMTCT	5.3	0.6
Hygiene	5.3	0.6

When respondents were asked if they had talked with someone about the messages in the SMGL campaign, just under half (49.3 percent) reported that they had discussed the messages with someone (Table 26). This varied significantly by district, with more than 70 percent of respondents in Kalomo reporting that they had discussed the messages of the campaign with someone,

compared to only 15.8 percent of respondents in Lundazi district. Similarly, this varied significantly by age group, with 87 percent of those between the ages of 30 and 34 reporting they had talked with someone, while only 32 percent of younger respondents between the ages of 15 and 19 years had discussed the messages with someone. Discussion of the campaign messages did not vary significantly by target audience, education level, literacy, or marital status. However, there was a clear trend observed by education level and literacy. More respondents with a higher level of education, and respondents that were literate, reported that they had discussed the campaign messages with someone than respondents with less education and those who were illiterate.

Table 26. Percentage of Respondents Who Talked With Someone About the Messages in the SMGL Campaign, by Sociodemographic Characteristics (n=152)

Sociodemographic Characteristics	Talked With Someone About Messages (%)
Target Audience	
Pregnant women	46.1
Mothers of children aged 0–6 months	52.6
*District**	
Kalomo	71.1
Lundazi	15.8
Mansa	68.4
Nyimba	42.1
Education Level	
None	35.3
Primary	45.3
Secondary	56.9
Higher	100.0
Literacy	
Literate	53.8
Illiterate	39.1
*Age Group**	
15–19	32.0
20–24	34.8
25–29	56.8
30–34	87.0
35–39	47.6

Marital Status	
Single	61.5
Married	48.5
Separated or Widowed	33.3
Total	**49.3**

*p ≤ 0.001

The majority of respondents reported discussing the campaign messages either with a friend or neighbour (56 percent) or with their spouse/partner (52 percent) (Table 27). Of the respondents who reported talking about the messages from the SMGL campaign with someone else, the most commonly discussed topics were the importance or need to save money during pregnancy (64 percent); danger signs during pregnancy, delivery, and postpartum and seeking care at their onset (60 percent); the importance of facility-based delivery (52 percent); and the importance of attending ANC early (45.3 percent) (Table 28).

Table 27. Person With Whom Respondents Discussed Messages From SMGL Campaign (n=75)

Person With Whom Respondent Discussed Message	Percentage of Respondents Reported
Friend/neighbour	56.0
Spouse/partner	52.0
Other family relation	29.3
Mother/mother-in-law	8.0
Health worker	6.7
Father/father-in-law	1.3

Table 28. SMGL Topics Discussed by Respondents (n=75)

Topics	% of Respondents Reported
Importance of saving money	64.0
Danger signs and seeking care at their onset	60.0
Importance of facility-based delivery	52.0
Importance of attending ANC early	45.3
Importance of having a good diet during pregnancy	9.3
Family planning methods and birth spacing	8.0
Safety during pregnancy	5.3
PMTCT	4.0
How to care for a baby	1.3
Importance of taking vitamin supplementation/medication during pregnancy	1.3

IV. Findings From In-Depth Interviews

The qualitative component of the study used in-depth interviews with Change Champions—Chiefs and other community leaders—and the District MCH Coordinators to assess how the Change Champion programme worked in each district and how it could be improved. Specifically, the interviews were aimed at assessing the following: (1) perceptions on roles and knowledge on safe motherhood, (2) the implementation and success or achievements of the Change Champion programme, and (3) the challenges the respondents faced and recommendations for addressing them.

4.1. Perceptions on the Role of a Change Champion

District MCH Coordinators

The four District MCH Coordinators were asked what it meant to be a Change Champion and about the role Change Champions played in promoting safe motherhood in their districts. The coordinators saw the Change Champions as educators and disseminators of information on ideal safe motherhood practices. They often cited visiting community members and holding meetings on safe motherhood, and promoting behaviour change as the role of Change Champions.

> *"Doing health talks by meeting women, men as well as families … they are between health workers and the community … advocating for good health … also encouraging male involvement."*

> *"They tell people not to deliver in villages"* and *"encourage them to deliver at the clinic."*

One coordinator added that Change Champions were well-known, influential community members who led by example and were easily listened to by their community members. The coordinator mentioned chiefs, headmen, and traditional leaders as examples. Another added that Change Champions were individuals who wanted to change the way community members viewed safe motherhood issues.

Chief Change Champions

Of the three participating Chiefs, two felt the orientation helped them clearly understand their role as a Change Champion. They believed their role was to use their leadership to gather their community members and address health issues that affected pregnant mothers and their babies.

> *"We are to use our influence in society to have an impact, to speak at functions and in villages about safe motherhood issues."*

> *"I gather people, mostly headmen, to discuss the plight of women and how we must encourage health centre delivery."*

One Chief was not able to identify his role or any training topics.

Other Change Champions

The Change Champions had a common understanding of their role in their communities. The majority of Change Champions envisioned themselves as influential community members tasked to change attitudes and behaviours related to safe motherhood—in particular, increasing facility-based deliveries, antenatal and postnatal care attendance, family planning, and male involvement.

> *"Actually, a Change Champion is a person like me who sit and teach people and explain about safe motherhood and how people should plan for their pregnancies and also how people should have safe deliveries. I also explain other things like family planning and how people should space their children and not having too many of those little ones. As a Change Champion, I encourage people to visit the hospitals and health centres each time they have a problem, and I want to change people's lives. So, that's just how I understand who a change champion is."*

Other Change Champions also saw their role as preventing maternal and child deaths, dispelling myths related to safe motherhood, identifying problems, and serving their community.

4.2. Perceptions on Safe Motherhood Knowledge and Training

Chief Change Champions

Participating Chiefs were asked about their motivations for becoming Change Champions and if they had prior knowledge about safe motherhood before the CSH orientation. The three respondents stated they had received no prior safe motherhood training, and only one mentioned having some knowledge before the orientation. The others were not familiar with the topic. The Chiefs listed a number of reasons for their motivation to participate in the program. One Chief felt that hehad already been addressing similar health issues and that the training further motivated and increased his knowledge. Another Chief felt motivated by an awareness of and concern over the number of childbirth deaths in their area, while the other pointed to his position and authority as Chief.

Two Chiefs indicated that the overall training was sufficient and left them feeling confident about their ability to discuss safe motherhood issues. Amongst others topics covered during orientation, they mentioned caring for pregnant women and their babies, encouraging the use of health facilities, encouraging early antenatal visits and registration, having a birth plan, receiving postpartum care, and remembering the six steps to safe motherhood.

All respondents mentioned the need for additional or frequent trainings. One Chief repeatedly expressed his concern over possibly not being able to answer the interview questions correctly and attributed it to insufficient training and the lack of post-orientation follow-up. Before abruptly ending and instructing his guard to complete the interview, the Chief was unable to identify any safe motherhood topics. His guard shared that they had stopped participating due to a lack of follow-up from their coordinator, adding *"we have SMAGs who go to villages to sensitize women about antenatal and the importance of going with partners … there is even punishment for the ones*

who refuse to go." A second Chief also expressed concern over not being able to answer questions but chose to continue the interview.

Other Change Champions

The other Change Champions cited a few different reasons for becoming Change Champions. Most Change Champions felt motivated to join the initiative because of what they witnessed in their villages—death during childbirth or death from pregnancy complications, poor attendance at AMC clinics, and limited family planning.

> *"What motivated me to become a Change Champion is because of a lot of suffering … on the part of women. You will find that women are giving birth in homes, while others are dying of pregnant-related complications. Some of them don't go and register for antenatal visits when the hospital was teaching us. It's when I realised that there is need for things to change, that was when I became a Change Champion for things to change."*

The remaining Change Champions explained that their commitment to the general well-being of women and children, as well as their experience doing volunteer work and community development for other projects, motivated them to join the initiative.

All of the Change Champions reported receiving a training covering a range of topics related to safe motherhood. The Change Champions most commonly cited that the training covered issues related to ANC and the birth plan. Other common topics in the trainings included facility-based deliveries, male involvement, postnatal care, family planning, maternal and child nutrition, hygiene, pregnancy danger signs, and dangers of early marriages. A few Change Champions also reported discussing programme reporting, PMTCT, male circumcision, malaria prevention, and common myths about pregnancy and delivery. Several of the Change Champions also mentioned learning about the six steps of safe motherhood, but only a couple were able to explain the steps when asked by the interviewer.

About half of the Change Champions had received previous trainings that addressed safe motherhood topics. They specifically mentioned being trained in family planning (including condom use and birth control pills), ANC, and PMTCT. One champion was a trained and practicing midwife. These Change Champions received training from various sources, including St. Francis of Midwifery, the United States Agency for International Development (USAID), Child Fund, World Vision, and local SMAGs and health workers.

In terms of the effectiveness of the Change Champions training, the Change Champions appeared to be equally divided. Half of the Change Champions found that the training was sufficient in preparing them for their work in the communities. "*The training was enough because we understood everything very well and after lessons they could ask us different questions based on what we were doing. We were also free to ask them where we were not very clear."* Many of these Change Champions found that the field mentorship following the initial orientation solidified the lessons and allowed an opportunity to ask questions. The other half thought the training was too short and

required either a medical background to grasp the information or follow-up trainings to provide further details on the many safe motherhood topics.

Responses to probing questions on the effectiveness of the training resulted in some conflicting results. Despite the division in opinion on the sufficiency of the training, the majority of the Change Champions felt the trainings helped them to better understand their roles as Change Champions. The overwhelming majority also reported feeling confident discussing safe motherhood topics in their communities. However, half of the Change Champions still felt uncomfortable providing information on a range of topics. These topics included postnatal danger signs, ANC, female condoms, breastfeeding for HIV-positive mothers, child spacing, differences in exclusive and complementary breastfeeding, family planning, and determination of the delivery due date.

4.3. Implementation of Change Champions Programme

District MCH Coordinators

When asked about organisation—how the Change Champions were selected, whether they worked with the Change Champions and met at the district level, and if they involved other community safe motherhood volunteers—District MCH Coordinators offered mixed responses and revealed some implementation challenges.

Selection of Change Champions

Most of the communities followed a common process for selecting Change Champions. Most of the coordinators reported focusing their selection efforts on influential leaders in the community and inviting them to participate. "*The Change Champions were selected using influential people such as headmen, Chairmen, Chiefs, and those people who are popular in our community,"* said an MCH Coordinator. One of these coordinators reported that his DHO sent a letter inviting these leaders to serve as Change Champions. One coordinator was new to the position and was unaware of the selection process.

Implementation Activities

All of the coordinators explained that Change Champions implemented the programme by delivering health talks and in some cases speaking with community members one on one. A couple of the coordinators emphasised educating communities about the need for facility-based deliveries and the possible penalty for delivering in the village.

> *"They've put a penalty for anyone who delivers into the community that maybe they are going to pay a certain amount of money, not necessarily charging them but to encourage them to deliver at the clinics … they tell them they'll have to pay an amount they can't afford so they'll deliver in a clinic out of fear they can't pay or 'the chief can chase them out of the village' ... to encourage them."*

Other coordinators reported that their Change Champions also focused on the importance of early ANC and male involvement, and the dangers of not practicing safe motherhood.

Coordination With Other Change Champions and DHOs

Most of the coordinators highlighted that many Change Champions worked together in groups when visiting communities and conducting health talks. One coordinator found groups of male and female Change Champions to be useful when speaking with different community members. Another coordinator thought Change Champions supporting one another during community visits was important in the event that one coordinator was unable to address a specific community question, as the other champion could step in.

Despite the efforts of the group outings, coordination of Change Champions at the district level appeared to be a challenge. Some participants indicated limited interaction at the district level, stating that they had never met or had only done so once. One coordinator attributed the lack of interaction to having a busy schedule and a difficulty in dealing with Chiefs. *"It's not very easy when you are dealing with Chiefs to just call them and say 'let's go this way, let us do that,'"* the coordinator stated. The coordinator added that reaching pastors and other community members was easy, but Chiefs were "*very dignified,*" so "*someone at a higher level*" needed to reach them. The respondent suggested that the District Commissioner could work with the Chiefs, concluding that he was in charge and "*the one who is supposed to call these meetings*."

Coordinators differed in their opinions on whether the programme was reaching their entire district. A couple of coordinators noted that it was difficult for DHO staff to travel across their districts due to hectic schedules and poor transportation options, but they felt confident that the Change Champions stationed in the villages would reach their designated populations. Two coordinators reported using a zone system for their Change Champions to ensure coverage of the villages without overlap. Another coordinator also explained their plans to use local radio and the distribution of fliers to help spread safe motherhood information throughout the district.

Most coordinators believed that Change Champions are linked to the DHO. They reported that the office works "*hand in hand*" with the Change Champions by providing materials and support when they encounter challenges with implementing the programme in their communities. One coordinator specifically mentioned that hisoffice has a Change Champion Chairman to serve as the primary point of contact for their Change Champions. Although most of the coordinators stressed a clear linkage, one coordinator underscored the difficulties in reaching some of his Change Champions due to hectic schedules and a lack of commitment on the part of the Change Champions.

Coordination With Other Safe Motherhood Groups

Most of the coordinators also reported collaborating with other safe motherhood groups and volunteers—including SMAGs, NHCs, growth promoters, and health educators. All of the coordinators stressed that these groups conduct activities that are similar to those of the Change Champions in the same communities, and in some cases these groups have stronger interpersonal

relationships with the communities. To help connect the work of the Change Champions to other groups, two coordinators mentioned inviting the other groups to their events and disseminating information to use with community members. One coordinator reported not working with other groups at all, despite hisconnections to the communities, because hs has been unable to schedule a meeting with them.

Chief Change Champion

Implementation Activities

Two of the Chiefs explained that they organised the community by using their leadership position to gather and train others (mostly Indunas and headmen), and then working with them to spread information about safe motherhood practices.

> *"I first sent word out that all the headmen should come here (the palace) for a meeting. When they came for this meeting, I told them all I had been taught at the orientation, such as early antenatal booking and emphasised that they must keep a look out for pregnant women and ensure that they all deliver at the health centre. Also, that anyone who delivers at home would be summoned to the palace to pay a fine. After that, the meetings that followed was for everyone in the community."*

> *"Immediately after I came from Lusaka, I invited village headmen from two wards and a total number of 75 village headmen … after that we made another meeting which had 26 … I have seven wards so I picked key figures from each ward to lead."*

> *"[W]e quickly send them (community leaders) out to go and sensitize others, to say this is what has come from the palace, and his royal highness wants to do this on these issues … they will quickly come back here and say that we have gone out but these are the issues, so we can quickly settle them and be able to implement the programmes quickly, efficiently, and effectively."*

One Chief mentioned leveraging other activities (e.g., quarterly Chief council meetings, visits to sub-chiefs or headmen) and using them as opportunities to spread messages about safe motherhood practices to community members. This Chief also reported tasking Indunas with the responsibility of reaching all villages in each of their wards, addressing traditional issues that affected safe motherhood, and providing reports on their area during the Chief's council meetings. Further, the Chief detailed how he or she selected three leaders from each of his or her seven wards to serve as Change Champions and used Ward Counsellors to address issues and report on maternal deaths during meetings with government officials.

To both Chiefs, the Indunas played a key role in collecting information and reporting on their wards. *"They write progress reports for me to take to the district health office, and then the district health office comes here to see how things are going here in the community,"* reported the other Chief.
Coordination With the DHO

The Chiefs mentioned good coordination with District Health Officers, stating that they provided the officer status reports and were in constant touch. In addition, they shared that they received material from them that supported their efforts, with one chief adding that he preferred to work with government officials, as "*that is where the money is and what can we Chiefs offer [people]?*"

Coordination With Other Change Champions and Safe Motherhood Groups

Chiefs coordinated with other area Change Champions and community volunteers, such as SMAGs, women's groups, and HIV/AIDs action groups. The Chiefs believed this was advantageous, as their members knew the community well. However, they saw distance and the lack of adequate transportation as barriers to meeting and improving coordination. One Chief mentioned that he also worked with nurses but found them not responsive to coordination. "*They say they don't want a programme, to be told what to do, [and] that they know what they are doing*," he responded. Another Chief stated that he had asked the area District Commissioner about ways to coordinate efforts but did not hear back.

Other Change Champions

Implementation Activities

The Change Champions reported implementing the programme through a few types of activities. Most of the Change Champions explained holding meetings in the community or speaking at meetings held by other organisations, such as local churches, women's groups, and sports teams. In the meetings, they explained their role and provided basic information on safe motherhood. A few of the Change Champions reported distributing the birth plan during the meetings. Several Change Champions also discussed going door to door to speak with women and their families and working with community leaders (e.g., Chiefs) to call attention to the project. One champion reported moving expectant mothers to the women's shelter to wait for delivery at the health facility. Another champion reported collecting the contact information of pregnant women at meetings to conduct a follow-up visit on birth planning.

Coordination With Other Change Champions and DHO

About half of the Change Champions reported working with other Change Champions by hosting meetings, visiting local hospitals, and travelling to the resource centre. Other Change Champions indicated that far distances and lack of transportation inhibited their abilities to work with other Change Champions.

Coordination of Change Champions at the district levels followed a similar pattern. About half of the Change Champions reported meeting on a regular basis, mostly meeting quarterly, monthly, or as needed. A few of the Change Champions mentioned meeting only once, while two stressed never meeting at the district level due to hectic schedules and lack of transportation. Of those who did meet, common discussion topics for the meetings included planning for health talks, performance

and challenges, coordination of resources, and support of SMAGs. *"I would say to share our performance, what is going well, and the challenges we have so that we share opportunities, challenges, and solutions. At these meetings, we receive encouragements from health workers in the district, the DMO, the MCH Coordinators, and other leaders,"* said a Change Champion.

Some of the Change Champions explained that the coordination with other Change Champions was helpful. They learnt ways to address challenges when speaking with women and their families, the importance of working with Chiefs and other key stakeholders, and the usefulness of having another champion to help respond to community questions. The most common challenge to working with other Change Champions was the lack of transportation, followed by lack of regular meetings, relationship building, and commitment on the part of some Change Champions.

The Change Champions varied in their opinions on whether the programme was reaching the entire district. A quarter of the Change Champions thought the programme successfully reached the entire district through a zoning system and special field trips for Voluntary Counselling and Testing Day, World Malaria Day, and World AIDS Day. Conversely, a few of the Change Champions adamantly said that the programme was not reaching the entire district due to an insufficient number of Change Champions and a lack of transportation.

Coordination With Other Safe Motherhood Groups

All but one Change Champion discussed working with other safe motherhood groups when implementing the programme. Most Change Champions reported working with SMAGs, noting that they do much of the same type of work, but they found it helpful to collaborate in disseminating and counselling women and their families on the birth plan. Similar to the Chief Change Champions, several Change Champions also mentioned coordinating with community health workers, women's groups, community volunteers, Chiefs, and headsmen. A couple of Change Champions also worked with PMTCT lay counsellors, traditional birth attendants, and the NHC. In addition to their work with SMAGs to disseminate and counsel on the birth plans, Change Champions reported collaborating with their partners to

- Hold health talks on a range of safe motherhood issues;
- Provide safe motherhood reports (e.g., pregnant women, facility deliveries, registration for facility deliveries);
- Share safe motherhood information for dissemination; and
- Use influence (Chiefs and headmen) to organise community members for health talks and to charge penalties for home deliveries.

The most commonly cited challenges to working with other safe motherhood groups was the lack of transportation for meeting and the groups' expectations of incentives for partnering with the Change Champions. Other champions also reported being challenged with the lack of authority to correct partners for relaying incorrect information, and unknowingly working with volunteers with bad reputations in the community or a limited knowledge of safe motherhood.

4.4. Mobilization and Perceived Achievements of Change Champions Programme

District MCH Coordinators

Most of the coordinators believed they had been successful in mobilizing their communities to practise safe motherhood. They discussed several strategies they viewed as being successful—including selecting Change Champions who are influential figures in their communities, taking advantage of opportunities to talk about safe motherhood in everyday situations (e.g., shopping or working at the markets), and using radio to promote in-person health talks. These coordinators claimed that, as a result of the Change Champion programme, there was been an increase in facility-based deliveries, ANC visits, and male involvement. One coordinator could not state whether the programme has been successful in his district because he has not met with or received any feedback from his Change Champions.

Chief Change Champions

The Chiefs primarily used headmen, training them on safe motherhood practices, using them to reach all of their wards, and relying on them to collect status reports. The reports gathered information on the number of pregnant women and related deaths in assigned areas; Chiefs then shared the reports with District Health Officers and District Commissioners. These reports facilitated collaboration between Chiefs and district offices, helping them ensure that all pregnancy and pregnancy-related deaths are captured, assess how well a Chief's region faired, and identify issues of concern that need to be addressed.

Holding community meetings and having other community groups assist were also common methods. The respondents felt these methods were successful and had seen results such as fewer maternal deaths, increased health facility deliveries, more women seeking ANC, fewer C-sections needed for young mothers, and increased male involvement in safe motherhood practices in their areas. "*It is not like before, where it was considered an issue for only women to be concerned about*," stated a Chief. Another Chief shared that he had people mold bricks and donated his own resources to build a mother's shelter, adding that people are more likely to pay attention and receive safe motherhood messages if the project is "*materialised*."

Other Change Champions

Most of the other Change Champions believed their activities were successful in mobilizing communities around safe motherhood. Change Champions most commonly reported their most successful strategy as involving influential community leaders to encourage community members to attend events and practise safe motherhood behaviours. Several other Change Champions found success in mobilizing by promoting events over the radio, conducting health talks, going door to door, working with women's groups, and disseminating information in workplaces (e.g., markets and farms). These strategies predominately focused on facility-based deliveries, ANC, postnatal care, male involvement, family planning, and birth planning.

Most of the Change Champions reported seeing changes in safe motherhood behaviours in their communities and believed the changes to be a result of their efforts. Change Champions most commonly cited an increase in facility-based deliveries and early ANC visits. One Change Champion said, "*Seen people go to clinics, register, and deliver, which is a big change because people—including my own relatives—didn't use to go."* Change Champions also witnessed an increase in male partners bringing women to the health care facility for ANC and delivery; an increase in women using family planning options; and a reduction in pregnancy-related deaths, number of pregnancies, and early marriages.

When asked what factors enabled them to perform well, Change Champions gave similar responses. They most commonly spoke of their commitment and passion for improving the lives of women and children. Several Change Champions also discussed the training and ability to review the guidelines provided in the training as a factor in supporting their performance. Other factors included good communication skills, existing positive relationships with communities, and their family's encouragement.

4.5. Challenges and Recommendations

District MCH Coordinators

The coordinators cited several challenges in implementing the programme. All of the coordinators stressed a problem in transportation when trying to gather Change Champions for meetings and for supporting Change Champions travelling to communities, especially in districts with a great distance between villages. Another common challenge was a lack of supplies (e.g., paper and pens) for preparing reports. Other reported challenges included lack of participation incentives for Change Champions and hectic DHO work schedules, which inhibited efforts to schedule meetings with Change Champions. To address these challenges and to improve the programme, District Coordinators recommended the following:

- Increase the number of Change Champions per village, and train them as a group;
- Expand recruitment of Change Champions to include church leaders and women who will work with the Chiefs;
- Provide transportation and fuel;
- Provide protective clothing for the rainy season;
- Provide printed brochures in English and local languages;
- Provide incentives to Change Champions, such as soap or allowances for lunch or transportation; and
- Provide identification cards or t-shirts to distinguish the Change Champions from the rest of the community.

Chief Change Champions

The Chiefs shared some challenges with regards to mobilization of their community and implementation of the programme. For community mobilization, they mentioned working with nurses, gender concerns, and traditional beliefs and myths as key barriers. Nurses, as mentioned

above, preferred to work independently and, further, some women did not wish to be cared for by male nurses. One Chief saw a lack of interest by males in practising family planning; women, on the other hand, believe "refusing" a husband is taboo and that it can destroy their home. The Chief also shared that community members often argue that their ancestors did not deliver in facilities but did not elaborate on the other barriers.

With implementation of the programme, the Chiefs pointed to distance and the lack of adequate transportation, a lack of various programme resources, insufficient coordination, and a need for additional training. They offered the following recommendations as solutions for addressing the challenges and improving the Change Champion programme:

- Provide trainings on a regular basis,
- Include trainings that allow Change Champions to understand why some are resistant to accepting messages, and offer guidelines for convincing them and workshops on presentation,
- Select and train those who "can be taught,"
- Increase the role of the government and nongovernmental organisations (NGOs),
- Provide meals (e.g., breakfast, lunch, snacks) for meetings, and
- Provide transportation and fuel.

Other Change Champions

- .

Change Champions also indicated facing many challenges in their attempts to mobilize communities. They most commonly reported community members being unable to travel to meetings due to a lack of transportation. Two other common problems were community expectations of incentives or meals for attending events and hostility or unwillingness to discuss safe motherhood, especially on the part of male partners. Other challenges included lack of identification cards, dispelling of myths, and community leaders who are not fully committed.

> *"Challenges of transportation and meal allowances, we have communicated this to the district medical office and are hoping they can do something about it. However, we have also tried to share communities in such a way that each of us operates within their nearest communities, though I have to say distances remain. On hostility among some men to programme activities, we inform the traditional leaders, who in turn summon such men and punish them. This has greatly helped."*

The Change Champions suggested a number of solutions to address the main challenges mentioned. Some Change Champions found that creating a zoning system has helped the issue of transportation. A couple of Change Champions also mentioned pooling resources to help provide food to meeting participants. Several Change Champions recommending providing districts with funds to give incentives to meeting participants and to train more Change Champions, particularly community leaders and men, to address the issues of reaching more communities and encouraging

openness to discuss safe motherhood. Another champion recommended providing t-shirts to help identify them as Change Champions.

The other Change Champions provided a number of recommendations on how to improve the programme training. Change Champions most commonly suggested providing incentives to training participants to pay for the costs of transportation, lodging, and food. This suggestion was closely followed by increasing the number of the training days to allow for more discussion, providing print lesson materials, training more Change Champions to cover all of the zones, and reaching beyond the district level to community level. "*I would recommend that these lessons are also extended from the district level to the ground level where even the people working at the grassroots should also have a feel of them*," said a Change Champion. A few of the participants also discussed the problems with training the Change Champions and Chiefs together because Chiefs have different roles and are provided incentives. Other recommendations included:

- Provide more information on healthy hygiene and sanitation,
- Provide more information on maternal and child nutrition,
- Provide information on family counselling,
- Creating drama groups,
- Producing videos demonstrating male involvement,
- Providing identification cards or t-shirts,
- Increasing the number of training days,
- Facilitating the development of action plans with the DHO,
- Providing venues for meetings and visits from women,
- Offering follow-up trainings,
- Involve other ministries in the training and programme (e.g., Ministry of Education and Agriculture), and
- Conduct more field trips to remote areas that are not close to health facilities.

V. Summary and Discussion of Findings

5.1. Media Access and Viewership/Listenership

Overall, radio and mobile phone access in the household amongst the respondents was moderately high at about 62 percent for radio and 68 percent for phone. Overall, 65 percent of respondents reported listening to the radio and 35 percent stated that they listen to the radio on a daily basis. The most commonly listened to radio stations amongst all respondents were Radio 1, Radio 2, and Radio Chikaya.

5.2. General Exposure to SMGL Campaign

Just under half of respondents reported to have heard of the SMGL campaign. This varied by district and literacy. There was overall higher recall of the campaign amongst respondents from Kalomo and Mansa district and respondents who were literate. The most common source of exposure to the campaign was at a health facility (27.6 percent) and from print material (13.8 percent), which likely referred to the pictorial birth plan.

5.3. Exposure to the Birth Plan

The birth plan was the most commonly recalled component of the campaign, with just over 70 percent of respondents reporting that they saw the birth plan. Exposure to the birth plan varied significantly by target audience, with more mothers of children aged 0–6 months reporting that they saw the birth plan than pregnant women. Similarly, exposure to the plan also varied significantly by district, with more respondents from Nyimba, Mansa, and Kalomo districts (all over 70 percent) reporting that they saw it, compared to Lundazi district (52.6 percent). Of all respondents, 47.4 percent received their own copy of the birth plan. The majority of respondents received the birth plan from a health worker at a health facility, and most (80 percent) reported that someone explained the birth plan to them. In terms of the timing of receipt of the birth plan, the majority (62.5 percent) received the birth plan during their second trimester in their pregnancy. The most commonly recalled information from the birth plan came from the education, logistics, and nutrition and care sections. Similarly, the most common uses reported for the birth plan were to learn about the danger signs, prepare the logistics for delivery, and save money, which were all presented in the most commonly recalled sections of the birth plan. Overall, respondents perceived the birth plan to be easy to use and useful, and they would recommend its use to a family member or friend.

5.4. Exposure to Safe Motherhood Radio Adverts

Respondents' exposure to the Safe Motherhood radio adverts was overall low, at about 20 percent. Recall of the radio adverts was slightly higher amongst those who had access to a radio in their household, at about 30 percent. Recall of the radio adverts varied by district, with higher recall in Mansa district (34 percent) compared to only 8 percent in Nyimba. These differences are likely due to lower radio access and listenership in Nyimba, as well as higher coverage of the radio adverts in Mansa and Lundazi districts compared to Nyimba. Amongst respondents who reported they had seen the radio adverts, the most commonly recalled messages were: the importance or need for

saving money during pregnancy; the importance of attending ANC early and delivering in a health facility; and the danger signs to watch out for during pregnancy, delivery, and/or the postpartum period and to seek care immediately at their onset. Of the respondents who had heard the radio adverts, their overall perceptions were positive. They felt that they understood the messages presented in the adverts, that the information presented in the adverts was important and relevant, and that adverts made them seriously think about how to achieve better health for themselves and their baby during and after pregnancy.

5.5. Perception of Impact on Knowledge, Attitudes, and Behaviour

Overall, respondents perceived the campaign to have an impact or influence on their knowledge and behaviour. Just over 80 percent of all respondents reported that the campaign messages changed their knowledge, and just over 70 percent felt that the campaign had an influence on their behaviour. It is important to highlight, however, that there is likely to be some over reporting of impact/influence by respondents, as less than 80 percent of respondents were able to actually recall a specific component of the campaign. Amongst only the respondents who were able to recall at least one component of the campaign, about 92 percent stated that they learnt something from the campaign and 82 percent reported that the campaign had an influence on their behaviour. The main messages that respondents reported to have learnt and how the campaign influenced their behaviour were aligned with the most commonly reported topics and messages recalled by respondents from the different campaign components (e.g., the birth plan, the radio adverts, the television programme, and interaction with the Change Champions). Thus, it is evident that there was good consistency in the messages promoted across all the campaign components and overall high recall and perceived influence of these main messages.

5.6. Interpersonal Communication

The majority of respondents (about 70 percent) reported that someone had discussed safe motherhood messages with them in the past 6 months. Of these respondents, the majority reported that they had discussed safe motherhood with a health worker or a SMAG member. About 15 percent of respondents recalled having discussed (either spontaneously or when prompted) safe motherhood with a Change Champion in their community. This coverage is as expected, since many of the Change Champions reported working collaboratively with health workers, SMAGs, and other community-based organisations (CBOs) to promote and disseminate safe motherhood messages. The challenge of adequate transport for the Change Champions to travel across the districts as well as the limited number of Change Champions engaged per district also helps explain why there was lower coverage of interpersonal communications with Change Champions and higher coverage amongst health workers and SMAGs.

As with the other campaign components, the main messages reported to have been discussed with a Change Champion were similar: the importance of/need for saving money, importance of attending ANC early and delivering at a health facility; the danger signs to watch out for during pregnancy, delivery, and/or postpartum; and the importance of seeking care immediately at the onset of these danger signs.

Just under half of respondents reported that they spoke with someone else about the messages in the SMGL campaign. The main topics discussed were the same as those discussed with the Change Champions, and the most commonly reported person with whom respondents talked were a friend or neighbour and their spouse/partner.

5.7. Role and Background of Change Champions

There was an overarching consensus amongst the District MCH Coordinators, Chiefs, and other Change Champions about the role of the Change Champions in the community. They were primarily seen as educators and disseminators of information, with the aim of promoting safe motherhood attitudinal and behavioural changes related to their communities/districts. Furthermore, they were perceived as influential community members or leaders.

Prior knowledge of safe motherhood amongst the Change Champions varied considerably. Some Change Champions had received additional trainings on safe motherhood through other organisations or donor agencies. There were mixed responses amongst the Change Champions as to whether the training was adequate; about half felt the training was sufficient, while the other half felt the training was too short. It is important to note that this gap was identified early on by CSH, and therefore additional field mentorship was provided to Change Champions. This additional mentorship was noted by the Change Champions as helpful in solidifying the topics covered in the orientation. In general, the Change Champions felt that the training helped them to understand their role as Change Champions and to be comfortable discussing safe motherhood issues in their communities. Further training was seen as more useful in terms of being able to comfortably understand and discuss all the topic areas or issues they felt they were expected to be able to address related to safe motherhood in their communities.

5.8. Implementation of the Change Champions Programme

The selection of the Change Champions was the same across the districts, with the aim of selecting influential leaders or members of the community. In general, the main activities implemented by the Change Champions included delivering health talks through a variety of forums such as community meetings, women's groups, and church events. Additionally some of the Change Champions reported speaking with community members one on one or going door to door to speak with community members on safe motherhood issues.

There was some coordination across some of the Change Champions; with some champions reporting that they worked together to visit communities and conduct health talks, but this was not consistently reported across the Change Champions. All respondents reported that coordination at the district level encountered challenges due to a number of factors, such as lack of adequate transportation and funds for coordination meetings as well as busy schedules for the Chiefs. In general, there was good coordination with other community groups, including SMAGs, NHCs, health educators, women's groups, and other community health workers; however, this wasn't the case for all Change Champions.

5.9. Achievements of Change Champions Programme

Overall, the District Coordinators and the Change Champions felt they were successful in mobilizing their communities around safe motherhood. For the Chiefs specifically, they explained that they trained and used their headmen to help mobilize and disseminate information in the communities. Change Champions also explained that they were able to leverage and take advantage of already existing structures to promote the messages, such as through other community groups, via community meetings, and even through the radio. On the whole, the use of influential leaders for the programme was perceived to be a successful strategy.

In terms of achievements in safe motherhood, the majority of respondents reported that they saw improvements in safe motherhood behaviours including, for example, increases in facility-based deliveries and ANC attendance, improvements in male involvement, and fewer maternal deaths.

5.10. Main Challenges of Change Champions Programme

The main challenges noted amongst respondents were the lack of adequate transportation and funds, which impacted coordination across the Change Champions and coordination at the district level for the programme. Other challenges noted by some respondents were the lack of incentives for Change Champions, the expectation of incentives from beneficiaries and/or other groups with which the Change Champions coordinated, and the need for training more Change Champions to improve the coverage of the programme. While these were noted challenges by respondents, the programme strategy emphasised that the Change Champions see the programme/initiative as something to integrate into their already existing community activities to help ensure its sustainability. This was explained during the orientation; thus, CSH emphasised that additional funding for transport would not be available. Further, Change Champions received some material incentives for their participation in the programme (e.g., books for recording activities, bags with a Change Champion identification card, and other campaign materials and resources).

VI. Recommendations and Conclusion

Based on the main findings from the evaluation, the following is a list of recommendations for the SMGL campaign moving forward:

1. Overall, the majority of respondents were reached with safe motherhood messages either through the birth plan or interpersonal communication activities with health workers (including SMAGs) or Change Champions. Since this was the most effective way of reaching the target audience, the focus should continue on promotion of the messages through these communication channels.

2. The media plan for the Safe Motherhood radio adverts should be reviewed to ensure that they are airing on the most listened-to radio stations and during the most listened-to time periods for the target audience in the specific districts targeted for the campaign.

3. In general, respondents' reported discussions and interactions with the Change Champions were lower than with health workers and SMAGs. This lower coverage was likely due to the challenge of transportation and the limited number of Change Champions working across the four districts. Since health workers and SMAGs are able to extend greater out into the communities, it will be important for the initiative to continue work with all of these different cadres of workers to continue to promote the messages of the campaign and encourage changes in the target audiences' attitudes and behaviours.

4. The strategy of selecting influential community leaders or members worked well for the Change Champions programme, as did collaboration with other key stakeholders (e.g., health workers, SMAGs, NHCs, and other CBOs). It was evident that the busy schedules of the Chiefs and the challenge of adequate transportation made it difficult for Change Champions to cover an entire district. Thus, it was effective to have the Chiefs act more as leaders, and collaborate and coordinate the work with other key community members to disseminate the messages. Moving forward, it is suggested that additional influential leaders from the communities be engaged to help improve coverage across the targeted areas.

5. Since some of the Change Champions did not feel the initial orientation was sufficient in preparing them with information on all safe motherhood topics, it will be important to continue providing them with additional mentorship as they implement the programme. This will be particularly important for those with less background on safe motherhood, as many Change Champions noted the usefulness of the additional mentorship.

6. With regards to the implementation of the Change Champions programme, since many of the Change Champions and District Coordinators requested additional resources for meetings to help improve coordination at the district level and additional incentives for the Change Champions, it will be important to better emphasise in the orientation and through direct mentorship that the aim of the programme is really to have the Change Champions focus on integrating the effort into their daily or normal community activities. The

programme was set up this way to help ensure its sustainability, rather than offering the Change Champion programme activities as separate and an additional campaign.

Overall, the SMGL campaign was well received by the community, particularly the pictorial birth plan and the interpersonal communication activities with the different health workers and Change Champions. Furthermore, there was great consistency in the messaging across the campaign's different components/communication channels, which was evidenced by respondents' recall of the key messages and the reported perceived impact on their knowledge and behaviour. Resources should be mainly targeted for expanding access to the birth plan and other interpersonal communication activities, as these were the most effective channels in reaching the target audience with the campaign messages.

VII. Appendices

Appendix 1. Rapid Survey Sampling Methodology

Lot quality assurance sampling methodology will be used for the rapid household survey. Since there are two sample groups of interest, pregnant women and mothers of children 0-6 months, parallel sampling will be used. The Zambia 2010 census data will be used to define the sampling frame for each survey. For this survey, the following steps will be used to develop the sample and selection of participants:

Steps for selection of interview sites within the four districts:

1. Within each supervisory area, census supervisory areas (CSAs) will be listed out. Using probability proportionate to size (PPS) sampling, 19 CSAs will be selected.

2. Within each CSA, all standard enumeration areas (SEAs) will be listed out and one will be randomly sampled. The selected SEA will be used as the interview site.

3. At each interview site, two participants will be interviewed. This will include one participant from each sample group, which includes: 1) pregnant women; and 2) mothers of children 0-6 months.

Steps for selection of a household within each interview site (SEA):

1. The interviewer will locate a central location within the interview site.

2. At the central location, a random direction will be chosen by using the spinning the bottle method.

3. A random number from 1-10 will be chosen. The interviewer will select the house that corresponds to the number chosen. For example, if the number 5 is selected, the interviewer will go to the 5th house from the central location (in the selected direction). In the event that there are less than 10 households in the selected direction, count the number of households (X) in the selected direction and select one number at random between 1-X.

Steps for selection of participants within the household:

1. At the selected household, a household listing of the people present who qualify from both sample groups (pregnant women and mothers of children 0-6 months) to participate will be conducted by the interviewer. It is permissible to select two participants from the two sample groups from one household as long as they are deemed eligible and both consent to participate. It is also permissible to select the two participants from the different sample groups from two different households.

2. In the event that there is one person from each sample group in the same household that are eligible to participate, both will be asked to participate. If one or both of the persons eligible do not consent to participate, the next closest home will be selected. For example, if a pregnant woman agrees to participate in the first selected household, but the mother of a child 0-6 months does not consent to participate, then the next closest household will be selected to see if there is an eligible mother. This process will be repeated until two

participants from the two sample groups have consented to participate in the survey per site.

3. In the event that there is more than one person from the same sample group (e.g., there are two pregnant women in the household) who qualifies to participate, the person whose birthday is closest to the date of survey visit will be selected to be interviewed. In the case that the person selected does not consent to be interviewed, the next eligible person in the household (based on the next following birthday) will be interviewed. This process will continue until an eligible person present in the household consents to the interview. If no one in the household consents to be interviewed, the next closest house will be selected.

4. In the event that there are no household members at the selected household that meet the eligibility criteria from the two sample groups, the interviewer will select the next closest house to interview.

5. Once the interviewer completes the interviews with the two participants, he/she will proceed to the next interview site and repeat the same steps for randomly selecting a household and participants.

Appendix 2. Rapid Assessment Survey Questionnaire

Saving Mothers Giving Life Campaign
August/September 2013

IDENTIFICATION	
PROVINCE: _____	PROVINCE: ☐☐
DISTRICT: _____	DISTRICT: ☐☐
SITE: _____	CSA/SEA:__/__/___ | __/__/__
RANDOM NUMBER SELECTED FROM CENTRAL	
LOCATION: _____I_____	

INTERVIEW INFORMATION	
DATE: ……../……../…..…	INTERVIEWER CODE: ☐☐
INTERVIEWER NAME: _____	
INTERVIEW START TIME: _____	
LANGUAGE OF QUESTIONNAIRE: _____	LANGUAGE: ☐☐

DATA QUALITY CHECK		
SUPERVISOR	EDITOR	DATA ENTRY CLERK
NAME:_____	NAME:_____	NAME:_____
DATE:_____	DATE: _____	DATE:_____
SIGNATURE:_____	SIGNATURE: _____	SIGNATURE:_____

Introduction and Consent

Interviewer: Introduce the study as outlined in the Information sheet and proceed with the interview as follows.

Please check to confirm that the participant has given consent to be interviewed:

YES ☐ NO ☐

Section 1: Background Characteristics

No.	Questions and Filters	Coding Categories	Skip
101.	How old were you at your last birthday?	Age in completed years.... ☐☐	
102.	Mark category:	Pregnant Woman…….. 1 Mother with child (0-6 months)……. 2	If mother -> Q104
103.	How old is your pregnancy?	0-3 months…… 1 4-6 months…….. 2 7-9 months…….. 3 Do not know……..... 9	Skip to Q105
104.	How old is your youngest child?	Age in completed months.... ☐☐	
105.	What is the highest level of education you have attended?	None…….. 0 Primary…….. 1 Secondary……. 2 Higher…… 3	
106.	Can you read and understand a letter or newspaper with ease in English or in a local language?	In English…… 1 In local language……. 2 Both English and local……. 3 Not at all…… 4	
107.	What is your marital status?	Single……. 1 Married…….. 2 Widowed…..…….. 3 Separated…….. 4 Divorced……..... 5	
108.	Do you/your household own the following? [*Record only items which have been functioning within 6 months*] Radio? Television? Mobile?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	

Section 2: General Exposure

201.	In the past 6 months, have you heard or seen any messages on Safe Motherhood?	Yes……... 1 No……. 2	If no -> Q204
202.	Where did you hear or see these messages? **[Spontaneous response only. Do not read out the list of responses.]**	Radio…… 1 Television…… 2 Print Materials……. 3 Community Activities……. 4 Newspaper…….. 5 Friend…….. 6 Community worker from local NGO……. 7 8 Other: _____ (SPECIFY) Do not recall……... 99	
203.	What was the name of the programme that brought you these messages? **[Spontaneous response only. Do not read out the list of responses.]**	Named Mothers Alive/SMGL 1 Named other Safe Motherhood Programme: _____ (SPECIFY) 2 Do not know…… 99	If named Mothers Alive/ SMGL ->Q206
204.	Have you heard, read or seen anything about a programme called Mothers Alive or Saving Mothers Giving Life?	Yes……... 1 No……. 2	If no -> Q301
205.	Where did you hear, read or see anything about the Mothers Alive or Saving Mothers Giving Life programme?	Radio…… 1 Television…… 2 Print Materials……. 3 Community Activities……. 4 Friend…….. 5 Community worker from local NGO……. 6 Health Facility/ Health Worker…… 7 Other: _____ 8	

		(SPECIFY) Do not recall……..……... 99	
206.	SHOW THE PARTICIPANT THE FOUR LOGOS (3 FAKE/1 REAL) AND ASK: Have you seen any of these logos before today?	Yes…….. 1 No……. 2	If no -> Q301
207.	Which one or ones have you seen (Circle all that apply)?	Logo 1…… 1 Logo 2……... 2 Logo 3…….. 3 Logo 4……... 4	
208.	Where did you see the logo that you just chose?	Television…….. 1 Print Materials…….. 2 Other: _____ 3 (SPECIFY) Do not recall……..…….... 99	

Section 3: Print Materials

No.	Questions and Filters	Coding Categories	Skip
301.	In the past six months, have you seen any print materials on Safe motherhood?	Yes……..... 1 No……. 2	If no -> Q401
302.	What print materials on Safe Motherhood have you seen? **[Spontaneous response only. Do not read out the list of responses.]**	Birthplan…….. 1 Chitenge…….. 2 Other: _____ 3 (SPECIFY) Do not recall……..…….... 99	If 1-> Q304
303.	Have you ever seen this birthplan before? **[Show respondents a copy of the birth plan. After they have seen the birth plan, remove it from their sight so they cannot reference it.]**	Yes……..... 1 No……. 2	
304.	Did you receive your own copy of this birthplan?	Yes…… 1 No……. 2	If no ->

305.	From whom did you receive the birthplan?	Health Worker…… SMAG…… Other Community Health Worker…. Other: _____ (SPECIFY) Do not recall……	1 2 3 4 9	
306.	During which month of your pregnancy did you receive the birthplan?	0-3 months…… 4-6 months…… 7-9 months…… Do not recall……	1 2 3 99	
307.	Did anyone explain the birthplan to you?	Yes…… No……	1 2	
308.	Who explained the birthplan to you?	Health Worker…… Change Champion/ Chief…….. SMAG…….. Other Community Health Worker.... Other: _____ (SPECIFY) Do not recall/Do not know……..	1 2 3 4 5 9	
309.	What are the main message(s) presented in the birthplan (Circle all that apply)? [**Spontaneous response only. Do not read out loud the list of responses**.]	**Education** (due date, labor signs, danger signs, breastfeeding, care for baby)…….. **Social Support** (support from family, male involvement)……. **Logistics** (Saving for transport and supplies)…… **Nutrition and Care** (Good diet, ITN use, Iron and folic acid tablets, vitamin A)……. **Medical** (Antenatal and Postnatal Care visits)…… Other: _____ (SPECIFY)	1 2 3 4 5 6	

		Do not recall……..... 9	
310.	How have you used/ did you use the birthplan?	To prepare logistics for the arrival of baby…… 1 To save money for transport/supplies for delivery…….. 2 To learn about danger signs……. 3 To learn about services provided at ANC…….. 4 To learn about facility delivery……. 5 To learn about how to care for baby…….. 6 To learn about how to involve partner/family…….. 7 Other: _____ (SPECIFY) 8 Other: _____ (SPECIFY) Do not recall……..... 9	

Interviewer text: I am now going to read a few statements about your perceptions of the birthplan. I am interested in the extent to which you agree or disagree with each statement. After I have read each statement, please indicate whether you strongly disagree with the statement, you disagree with the statement, you are neutral about the statement, you agree with the statement or you strongly agree with the statement.

Statement:		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
311.	I find the birthplan easy to use.	1	2	3	4	5
312.	I find the birthplan useful.	1	2	3	4	5
313.	The birth plan helps/helped me during my pregnancy to prepare for child birth.	1	2	3	4	5
314.	I follow/followed the monthly birth planning steps presented on the birthplan.	1	2	3	4	5
315.	I would recommend the birthplan to a family member or friend.	1	2	3	4	5

Section 4: Radio

No.	Questions and Filters	Coding Categories	Skip
401.	Do you listen to the radio?	Yes……..... 1	If no ->

		No……	2	Q501
402.	How often do you listen to the radio?	Daily……..	1	
		4-5 days in a week……	2	
		2-3 days in a week……	3	
		Once per week……	4	
403.	Which Zambian radio station(s) do you listen to the most, starting with the most listened to? Name up to three stations:	1._____ 2._____ 3._____		
404.	At what time(s) do you listen to the radio the most? Name up to three times in a day:	Early Morning (1:00-6:00)…… Morning (6:00-9:00)…… Mid-Morning (9:00-12:00)……..... Afternoon (12:00-15:00)…… Late-Afternoon (15:00-18:00)…… Evening (18:00-21:00)……... Late Evening (21:00-24:00)……..	1 2 3 4 5 6 7	
405.	In the past 6 months, have you listened to any radio advert/spot involving chiefs talking about safe motherhood?	Yes……. No……....	1 2	If no -> Q501
406.	Do you remember the names of the Chiefs in the radio advert/ spots?	Yes…… No…….....	1 2	
407.	What is/are the name(s) of the Chiefs in the radio advert/spot you listened to? **[Spontaneous response only. Do not read out loud the list of responses.]** **See List below:** 1. **Nyimba** (Chief Mumbi & Kathumba)) 2. **Mansa** (Chiefs Chisunka, Mibenge & Mwansakombe) 3. **Lundazi** (Chief Mpamba) 4. **Kalomo** (Chief Simamba)	Identifies at least one Chief…….. Fails to identify any Chief……..	1 2	
408.	What are the messages presented in the radio adverts/spots that you have heard (Circle all that apply)? [**Spontaneous response only. Do not read out loud the list of responses**.]	The need to prepare logistics (supplies/transport) for the arrival of baby……..……. The importance of early antenatal care attendance…….. Danger signs during pregnancy/ labour/ after child birth and the need for seeking care for these signs……..…… Importance of facility delivery……..…… Family planning methods and the	1 2 3 4	

		importance of birth spacing…….. 5 Other(s): _____ (SPECIFY) 6 _____ Do not recall/Do not know…….. 9	

Interviewer text: I am now going to read a few statements about your perceptions of the radio advert/spot. I am interested in the extent to which you agree or disagree with each statement. After I have read each statement, please indicate whether you strongly disagree with the statement, you disagree with the statement, you are neutral about the statement, you agree with the statement or you strongly agree with the statement.

Statement:		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
409.	I found the information in the radio advert/spot to be relevant	1	2	3	4	5
410.	I think it is important to follow what the chief was saying in the advert/radio spot.	1	2	3	4	5
411.	I understood the messages in the radio advert/spot.	1	2	3	4	5
412.	I found the message in the radio spot more useful since it was communicated by my chief.	1	2	3	4	5
414.	The radio spot made me seriously think about how to achieve better health outcomes during and after pregnancy	1	2	3	4	5
415.	The information in the radio advert/spot is important for women that are pregnant and their partners.	1	2	3	4	5

Section 5: Television

No.	Questions and Filters	Coding Categories	Skip
501.	Do you watch television?	Yes…….. 1 No…… 2	If no -> Q601
502.	How often do you watch television?	Daily…….. 1 4-5 days in a week…….. 2 2-3 days in a week…….. 3 Once per week……. 4	
503.	Which Zambian television channels/stations do you watch the most, starting with the one you watch most?	1._____ 2._____ 3._____	
504.	At what times do you watch television the most? Name up to three times in a day.	Early Morning (1:00-6:00)…….. 1 Morning (6:00-9:00)……. 2	

		Mid-Morning (9:00-12:00)……..... 3 Afternoon (12:00-15:00)……. 4 Late-Afternoon (15:00-18:00)…… 5 Evening (18:00-21:00)…… 6 Late Evening (21:00-24:00)……... 7	
505.	In the past 6 months, have you ever seen a television programme involving a Chief discussing safe motherhood?	Yes…….. 1 No…… 2	If no -> Q601
506.	What television channel(s)/station(s) did you see the programme on (Circle all that apply)? [**Spontaneous response only. Do not read out loud the list of responses**.]	ZNBC…….. 1 MUVI TV……. 2 Do not recall/Do not know…… 9	
507.	What were the names of the Chiefs who are featured on the television programme?	Yes…….. 1 No…… 2	
508.	Can you tell me the name(s) of the Chief(s) that featured on the programme? [**Spontaneous response only. Do not read out loud the answers listed below**.] **List of Chiefs:** 1. Chieftainess Nawaitwika 2. Chief Mumena 3. Chief Mphuka 4. Chief Nawasilundu	Identifies at least one Chief…… 1 Fails to identify any Chief…….. 2	
509.	What message(s) or lesson(s) are presented in the programme (Circle all that apply)? [**Spontaneous response only. Do not read out loud the list of responses**.]	The need to prepare logistics (supplies/transport) for the arrival of baby……..…… 1 The importance of early antenatal care attendance……. 2 Danger signs during pregnancy/ labour/ after child birth and the need for seeking care for these signs…….. 3 Importance of facility delivery……..…….. 4 Family planning methods and the importance of birth spacing…….. 5 Other(s): _____ (SPECIFY) 6 _____ Do not recall/Do not know…….. 9	

Interviewer text: I am now going to read a few statements about your perception of the television programme on Safe motherhood featuring Chiefs. I am interested in the extent to which you agree or disagree with each statement. After I have read each statement, please indicate whether you strongly disagree with the statement, you disagree with the statement, you are neutral about the statement, you agree with the statement or you strongly agree with the statement.

Statement:		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
510.	I found the information in the TV programme to be relevant.	1	2	3	4	5
511.	I would do what the chief was saying in the TV programme.	1	2	3	4	5
512.	I understood the messages in the TV programme..	1	2	3	4	5
513.	I found the message in the TV programme more useful because the message was said by my chief.	1	2	3	4	5
514.	I would recommend the TV programme to a family member or friend.	1	2	3	4	5
515.	The TV programme made me seriously think about how to achieve better health outcomes during and after pregnancy.	1	2	3	4	5

Section 6: Change Champions

No.	Questions and Filters	Coding Categories		Skip
601	Has anyone discussed Safe Motherhood with you in the past 6 months (alone or as a group)?	Yes……..	1	If no -> Q701
		No…….	2	
602	Who discussed Safe Motherhood with you? (Circle all that apply)? [**Spontaneous response only. Do not read out loud the list of responses**.]	Health Worker…….	1	
		Change Champion/ Chief……..	2	
		SMAG…….	3	
		Other Community Health Workers..	4	
		Other: _____ (SPECIFY)	5	
		Do not recall/Do not know……..	9	
603	Has any Change Champion/ Chief discussed safe motherhood with you either alone or as a group?	Yes…….	1	If no -> Q701
		No……..	2	
604	What topic(s) did you discuss? [**Spontaneous response only. Do not read out loud the list of responses**.]	The need to prepare logistics (supplies/transport) for the arrival of baby……..	1	
		The importance of early antenatal care attendance…..……..	2	
		Danger signs during pregnancy/ labour/ after child birth and the need for seeking care for these		

		signs…….....	3	
		Importance of facility delivery……..……	4	
		Family planning methods and the importance of birth spacing……	5	
		Other(s): _____ (SPECIFY) _____	6	
		Do not recall/Do not know…….	9	

Section 7: Facility delivery

Note: This section is for mothers with children 0-6 months only.

No.	Questions and Filters	Coding Categories		Skip
701.	Do you have any other child apart from the one who is aged 0-6 months?	Yes……..	1	If no -> Q801
		No……	2	
702.	Where was the youngest child aged 0-6 months born?	Health Facility…….	1	
		Home……	2	
703.	Where was the child before the one aged 0-6 months born?	Health Facility…….	1	
		Home…….	2	

Section 8: Perception of Impact

Note: If respondent answered "no" to all of the following questions, Q201, Q301, Q303, Q401, Q405, Q501, Q505, Q601 end the interview (this indicates he/she was not exposed to the Safe Motherhood Programme).

No.	Questions and Filters	Coding Categories		Skip
801.	Have you learned anything from the Safe motherhood programme messages you heard, saw or read about?	Yes…….	1	If no -> END
		No……...	2	
802.	What have you learned as a result of the Safe Motherhood programme messages [either through what you have heard, seen or read about the programme]? [**Spontaneous response only. Do not read out loud the list of responses**.]	The need to prepare logistics (supplies/transport) for the arrival of baby……..……..	1	
		The importance of early antenatal care attendance……..	2	
		Danger signs during pregnancy/ labour/ after child birth and the need for seeking care for these signs…….……	3	
		Importance of facility		

		delivery……..…….. 4 Family planning methods and the importance of birth spacing…….. 5 Other(s): _____ 6 (SPECIFY) _____ Do not recall/Do not know……. 9		
803.	Have you talked with anyone about the messages in the Safe Motherhood programme?	Yes…… 1 No……. 2		If no -> Q606
804.	With whom did you talk to about messages in the Safe Motherhood program (Circle all that apply)?	Spouse/Partner……... 1 Friend/Neighbor…….....…. 2 Mother/Mother-in-law……. 3 Father/Father-in-law…….. 4 Other family relations……. 5 Health worker……. 6 Other: _____ (SPECIFY)		
805.	What did you talk about (Circle all that apply)? [**Spontaneous response only. Do not read out loud the list of responses.]**	The need to prepare logistics (supplies/transport) for the arrival of baby……..…….. 1 The importance of early antenatal care attendance…….. 2 Danger signs during pregnancy/ labour/ after child birth and the need for seeking care for these signs…….…… 3 Importance of facility delivery……..……. 4 Family planning methods and the importance of birth spacing…….. 5 Other(s): _____ 6 (SPECIFY) _____ Do not recall/Do not know……. 9		
806	Has the Safe Motherhood programme influenced or changed your behavior in anyway?	Yes…… 1 No…….....…. 2		If no -> Q610

807	Did any specific Safe Motherhood programmes influence or change your behaviour?	Yes…… 1 No……..... 2	If no -> Q610
808	What programme(s) influenced or changed your behaviour?	Birthplan……... 1 Chiefs radio spots…….. 2 Chiefs TV program……..…… 3 Change Champion……..…….. 4 SMAGs…… 5 Other : _____ 6 (SPECIFY) Do not recall…….. 9	
809	How has the Safe Motherhood programme influenced or changed your behavior (Circle all that apply)? [**Spontaneous response only. Do not read out loud the list of responses.]**	Started attending antenatal care/attended ANC early in pregnancy……..…… 1 Started preparing/saving money for child birth…… 2 Involved family in child birth preparations…… 3 Went to health facility upon experiencing danger sign of pregnancy/during labour/after child birth……... 4 Gave birth in facility…… 5 Improved on dietary intake/ supplement intake during pregnancy or during breastfeeding.. 6 Started attending postnatal care……... 7 Improved breast feeding practices (e.g., positioning, exclusively breastfeeding)……..…… 8 Other(s): _____ 9 (SPECIFY) _____ (SPECIFY) Do not recall…… 99	

Interviewer text: I am now going to read a few statements about your perception of the Safe Motherhood beliefs and practices. I am interested in the extent to which you agree or disagree with each statement. After I have read each statement, please indicate whether you strongly disagree with the statement, you disagree with the statement, you are neutral about the statement, you agree with the statement or you strongly agree with the statement.

Statement:		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
810.	I fear that when I go for antenatal care I will be tested for HIV.	1	2	3	4	5
811.	It is beneficial for the mom and baby's health to attend antenatal care early in a pregnancy.	1	2	3	4	5
812.	I do not fear the process/experience of delivering a baby in a health facility.	1	2	3	4	5
813.	I believe that delivering from a health facility is safer than delivering a baby at home.	1	2	3	4	5
816.	Because the safe motherhood program, it was easier for me to involve and get support from my family during pregnancy and child birth.	1	2	3	4	5
817.	I am aware of the danger signs during pregnancy/ labour/ postpartum.	1	2	3	4	5
818.	I am more aware of the various safe motherhood services provided by health facilities	1	2	3	4	5
819.	I believe that the quality of care and treatment at the health facility in my community is adequate.	1	2	3	4	5
820.	I believe that it is beneficial/important to plan for child birth when one is pregnant.	1	2	3	4	5
821.	The messages in the Safe Motherhood programme are relevant for women in my community.	1	2	3	4	5

INTERVIEW END TIME: _____

END OF INTERVIEW

Appendix 3. IDI Guide for MCH District Coordinators

In-Depth Interview Guide

DISTRICT MCH COORDINATOR

INTRODUCTION

Good morning/afternoon. My name is _____ and I will be the interviewer for this session. I work for the Communications Support for Health (CSH) programme based in Lusaka.

If asked: CSH is a USAID-funded programme that fosters sustained individual and collective action for health through effective activities in information, education, and communication/behaviour change communication. It is comprised of staff from ICF International, Chemonics International, and the Manoff Group.

Today, we're going to discuss your opinions on the Change Champions programme in your community. We hope that this information will help us better understand how to best improve and provide support to this programme in the future.

I want to let you know that I'm not a medical professional, and I am not an expert on the subject matter we are going to discuss today. I am a trained interviewer. I want to hear your honest opinions about the topics we will discuss today. There is no right or wrong answer to the questions I'm going to ask. Please just relax and enjoy the discussion.

Please keep in mind that your participation in this discussion is completely voluntary. If for any reason you wish to leave the discussion, you may do so.

We're doing this as part of a project to implement effective communication channels to promote key safe motherhood behaviors and address current barriers to their practice. Other project staff from CSH may also be in the room to observe the discussion. Kindly state whether it is okay to continue with the discussion.

Interview Guidelines

Before we begin, I'd like to review some important points about today's discussion. We have a lot we're going to discuss, and I want to make sure you are informed about how it will work and your rights.

- You have been invited here to share your views, experiences and opinions.
- Your answers will be confidential, so feel free to say exactly what is on your mind. Nothing will be attributed to any particular person in our report.
- There are no right or wrong answers.

- This session will be audio taped. This allows us to capture everything that is being said today, and we will include the information in a report to our client.
- We have a note taker here in the room with us. His/her name is _____. S/he is here to make sure that we capture all of your comments in the case that something goes wrong with the recording. S/he has signed a confidentiality agreement, and won't be telling your comments to anyone. S/he will not be taking part in the conversation, so we can just pretend s/he's not there.
- You may excuse yourself from the conversation at any time for any reason.

Lastly, please turn off the ringer on your cell phone. Any questions before we start?

Ice Breaker:

Before we start this interview, please share with me what your role is as a MCH Coordinator and how long you have been in this position.

Section I: Selection of Change Champions

We would like to begin by discussing the Change Champions programme in your district.

1. How were the Change Champions selected in your district?
   Probe:
   - What criteria, if any, were used in selecting the Change Champions?
   - Who was involved in the selection process?

Section II: Implementation

2. What do you think it means to be a Change Champion?
3. What role do Change Champions play in promoting safe motherhood in their communities?
4. What, if any, events or activities have the Change Champions organized in their communities?
   Probe:
   - What safe motherhood topics have they focused on addressing?
5. How are the Change Champions organised at district level?
6. Do they work with other change champions?
   If yes, probe:
   - Please explain how they have worked together.
   - Do you think having them work together has improved the programme? If so, how?
7. Do you have meetings with them at district level?
   - If so, how often and what do you do during those meetings?
8. How do they ensure that they reach the entire district as a group?

9. Are they linked to the District Health Office? If yes, please explain how they have worked with the District Health Office.
10. Do they work with other safe motherhood community volunteers? If yes, please explain how they have worked with the volunteers.
11. What, if any, challenges have the Change Champions experienced in implementing this programme in their communities?

    If yes, probe:

    - Why do you think they have experienced these challenges?
    - Do you have any suggestions on how to overcome these challenges in the future?

Section III: Achievements

12. Do you think the Change Champions have they been able to mobilize communities around safe motherhood issues?

    If yes, probe:

    - How have they mobilized their communities?
    - Do you think the strategy/ies they have used to mobilize the communities has been successful? If yes, please explain why?
    - What, if any, actions have the communities taken to improve safe motherhood?
    - What changes, if any, have you seen in their communities as a result of their mobilization?

    If no, probe:

    - What challenges have the Change Champions encountered in mobilizing their communities?
    - How do you think these challenges could be overcome?

Section IV: Challenges and Recommendations

13. What challenges, if any, did you face in working with the change champions? If yes, how could these challenges be overcome?
14. What, if anything, do you think could be done differently to improve the work carried out by Change Champions?
15. What, if anything, could be done differently to better support Change Champions to mobilize their communities to action on safe motherhood issues?

Closing

Thank you very much for coming and for sharing your ideas with us—we really appreciate your time.

Appendix 4. IDI Guide for Change Champions

In-Depth Interview Guide

CHANGE CHAMPION

INTRODUCTION

Good morning/afternoon. My name is _____ and I will be the interviewer for this session. I work for the Communications Support for Health (CSH) programme based in Lusaka.

If asked: CSH is a USAID-funded programme that fosters sustained individual and collective action for health through effective activities in information, education, and communication/behaviour change communication. It is comprised of staff from ICF International, Chemonics International, and the Manoff Group.

Today, we're going to discuss your opinions on the Change Champions programme you have led in your community. We hope that this information will help us better understand how to best improve and provide support to this programme in the future.

I want to let you know that I'm not a medical professional, and I am not an expert on the subject matter we are going to discuss today. I am a trained interviewer. I want to hear your honest opinions about the topics we will discuss today. There is no right or wrong answer to the questions I'm going to ask. Please just relax and enjoy the discussion.

Please keep in mind that your participation in this discussion is completely voluntary. If for any reason you wish to leave the discussion, you may do so.

We're doing this as part of a project to implement effective communication channels to promote key safe motherhood behaviors and address current barriers to their practice. Other project staff from CSH may also be in the room to observe the discussion. Kindly state whether it is okay to continue with the discussion.

Interview Guidelines

Before we begin, I'd like to review some important points about today's discussion. We have a lot we're going to discuss, and I want to make sure you are informed about how it will work and your rights.

- You have been invited here to share your views, experiences and opinions.
- Your answers will be confidential, so feel free to say exactly what is on your mind. Nothing will be attributed to any particular person in our report.
- There are no right or wrong answers.

- This session will be audio taped. This allows us to capture everything that is being said today, and we will include the information in a report to our client.
- We have a note taker here in the room with us. His/her name is _____. S/he is here to make sure that we capture all of your comments in the case that something goes wrong with the recording. S/he has signed a confidentiality agreement, and won't be telling your comments to anyone. S/he will not be taking part in the conversation, so we can just pretend s/he's not there.
- You may excuse yourself from the conversation at any time for any reason.

Lastly, please turn off the ringer on your cell phone. Any questions before we start?

Ice Breaker:

Before we start this interview, Please share with me what your role is in this community and how long you've had the role as change champion.

Section I: Knowledge and Training on Safe Motherhood

We would like to start talking about issues related to the work you do as a Change Champion in your district.

16. What motivated you to become a change champion?
17. Did you receive an orientation on being a Change Champion in your community?
    If yes, probe:
    - What topics were discussed/covered in the orientation?
    - Did you feel that the orientation you received was sufficient to help you understand safe motherhood issues in your community? Please explain.
    - Did the orientation you receive from CSH help you understand your role in promoting safe motherhood in your community? Please explain.
    - After the orientation did you feel confident as a change champion to discuss various topics in safe motherhood with the community? Please explain.
18. Did you have knowledge in safe motherhood prior to the change champion orientation? If so, from where did you learn about safe motherhood issues?
19. Did you have any training related to safe motherhood prior to the change champion orientation you participated in?
    If yes, probe:
    - Who/What organization trained you?
    - When and where did it take place?
    - What aspects of safe motherhood where you trained in?
    - Did you find the training helpful for carrying out your role as a change champion? If yes, please explain how it was helpful?

20. Are there topics in safe motherhood that you do not feel knowledgeable enough to discuss with the communities? Please explain.
21. What, if any, recommendations do you have for how to improve the orientation provided for Change Champions?

Section II: Implementation

22. What does it mean to you to be a Change Champion in your community?
    Probe: What role do you play in promoting safe motherhood in your community?
23. What, if any, activities or events have you helped to organize for your community around safe motherhood?
24. Do you work with other change champions?
    If yes, probe:
    - Please explain how you've worked together.
    - Do you meet as change champions at the district level? If so, how often and what do you do during those meetings?
    - How do you ensure that you reach the entire district as a group?
    - What, if anything, have you learned from working with other change champions?

    If no, probe:
    - Have you had challenges working with the other change champions? If yes, what have the challenges been?
25. Do you work with the District Health Office?
    If yes, probe:
    - Please explain how you've worked with them.

    If no, probe:
    - Have you faced any challenges working with the district health office?
26. Do you work with other safe motherhood community volunteers?
    If yes, probe:
    - Please explain how you've worked with them. What has been their role?

    If no, probe:
    - Have you faced any challenges working with the volunteers?

Section III: Achievements

27. Have you been able to mobilize your communities around safe motherhood issues?
    If yes, probe:
    - How have you mobilized your communities?
    - Do you think the strategy/method(s) you used to mobilize the communities was successful? If yes, please explain why.
    - What, if any, actions has your community taken to improve safe motherhood?

- Where there any specific topic areas were you able to mobilize your community around (ANC, health facility based delivery, postpartum care, family planning, etc.)?
- What changes, if any, have you seen in your communities as a result of the mobilization/Change Champion programme?
- Have you faced any challenges in mobilizing your community(ies) around safe motherhood issues? If yes, what challenges?

If no, probe:

- What challenges have you faced in mobilizing your community(ies) around safe motherhood issues?
- How do you think these challenges could be overcome?
- Has your community(ies) taken any action to improve safe motherhood issues? If so, what actions?
- Have you seen any changes in your community as a result of the Change Champion programme? If yes, what changes?

Section IV: Recommendations

28. What are some of the factors that enabled you to perform well as a Change Champion in your community? Where there any factors that inhibited your work as a Change Champion? If so, please explain?
29. What, if anything, do you think could be done differently to improve the work carried out by Change Champions?
30. What, if anything, could be done differently to better support Change Champions to mobilize their communities to action on safe motherhood issues?

Closing

Thank you very much for coming and for sharing your ideas with us—we really appreciate your time.

Endnotes

[i] Freimuth, V., G. Cole, and S. Kirby. (2000). *Issues in evaluating mass media-based health communication campaigns*. WHO Monograph. Accessed July 12, 2013, from http://www.dors.it/marketing_sociale/docum/Eval_Media_Campaign_WHO.pdf.