POPULATION WELFARE DEPARTMENT
Government of Punjab

Punjab Family Planning Program

Primary & Secondary Healthcare Department

February 2025

Social & Behavior Change (SBC) Strategy for Family Planning in Punjab

Qadam Ba Qadam
قدم بہ قدم

PATHFINDER

Social & Behavior Change (SBC) Strategy for Family Planning in Punjab

February 2025

Acronyms and Abbreviations

ABR	Adolescent Birth Rate
ANC	Ante-natal care
AV	Audio-Visual
CBO	Community Based Organization
CCI	Council of Common Interest
CHW	Community Health Workers
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DoH	Department of Health
DPWO	District Population Welfare Office
FMKI	Family Members and Key Influencers
FP	Family Planning
FP/RH	Family Planning and Reproductive Health
FWA	Family Welfare Assistants
GoPb	Government of Punjab
HSS	Health System Strengthening
HTSP	Healthy Timing and Spacing of Pregnancy
IBM	Integrated Behavior Model
ICPD	International Conference on Population and Development
IEC	Information, Education, and Communication
IMR	Infant Mortality Rate
IPC	Inter-personal Communication
ISC	Inter-spousal Communication
KAP	Knowledge, Attitude and Practices
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
mCPR	Modern Contraceptive Prevalence Rate
MEL	Monitoring, Evaluation, and Learning
MICS	Multi Indicator Cluster Survey
MWRA	Married Women in Reproductive Age
NGO	Non-Governmental Organization
OB	Office Bearers
OCP	Oral Contraceptive Pills
PAFP	Postabortion Family Planning
PBC	Provider Behavior Change
PDHS	Pakistan Demographic and Health Survey
PPFP	Postpartum Family Planning
PpFP	Post-pregnancy Family Planning
PWD	Population Welfare Department
QBQ	Qadam-ba-Qadam Project
RH	Reproductive Health
RMNCH	Reproductive Maternal Newborn and Child Health
SAPM	Social Action and Planning Model

SEM	Social Ecological Model
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
TFR	Total Fertility Rate
ToR	Terms of Reference
TNSB	Theory of Normative Social Behavior
VCAT	Value Clarification and Attitude Transformation
WHO	World Health Organization

Table of Contents

List of Figures

List of Tables

Executive Summary

This SBC strategy document has been conceptualized to facilitate stewardship of Social and Behavior Change (SBC) for family planning and reproductive health by the Population Welfare Department (PWD), Government of Punjab (GoPb). It is designed to serve as a ***technical reference document*** capable of serving as ***input material to guide the co-creation of operational plans, including the collaborative development and validation*** of key resources and materials, and facilitating collaborative implementation, monitoring, and evaluation of the SBC strategy by stakeholders and development partners across districts of Punjab. Section 1 offers a contextually informed statement of need and a behavioral diagnosis for family planning behaviors in the province. Section 2 introduces the integrated SBC Framework, outlining the theory of change for altering behaviors among priority audience segments and the associated implementation framework. Section 3 details strategies and SBC interventional modalities segmented by audiences, providing a structured approach for engagement. Finally, Section 4 outlines a monitoring and evaluation plan to assess the strategy's effectiveness, ensuring accountability and continuous improvement.

The ***Needs Assessment*** provides a contextually informed statement of need and a behavioral diagnosis. The maternal and child health outcomes in Punjab are comparable to the national averages in Pakistan. However, Punjab faces notably higher infant and under-5 mortality rates, indicating gaps in reproductive and child health services, especially in rural areas. Fertility dynamics reveal variations between urban and rural regions, with urban areas exhibiting slightly lower total fertility rates and adolescent birth rates compared to rural areas. Punjab demonstrates a moderate level of demand for family planning satisfied by modern methods, albeit with disparities among geographical divisions. Urban regions generally exhibit higher rates of modern contraceptive prevalence compared to rural areas. Addressing unmet need, especially in divisions like Dera Ghazi Khan, requires targeted interventions focusing on both spacing and limiting births.

Contraceptive method preferences vary across Punjab, with notable disparities among divisions. Despite strong uptake of skilled birthing care and facility-based birthing care, access to family planning counseling and services presents challenges, and disparities persist between urban and rural areas. Improving access to skilled health personnel and integrating family planning into maternal and child health services are crucial steps toward addressing these barriers and ensuring comprehensive care for women across Punjab, regardless of where they deliver.

The ***Educational and Ecological Assessment*** of family planning behaviors in Punjab reveals intricate psychosocial and contextual factors influencing individual behaviors, influenced by system-level policies, institutions, and community dynamics. Applying a gender lens and the PRECEDE Framework, we unveil crucial insights into the role of men and the ecological determinants of poor FP/RH behaviors among women.

In examining family planning, gender dynamics play a significant role, with men's readiness and household decision-making impacting uptake. Traditional gender roles, influenced by social, cultural, and religious factors, perpetuate stereotypes and limit men's engagement in FP/RH. However, there are shifting attitudes among men, recognizing the benefits of family planning in reducing financial burdens and improving spousal communication, yet challenges persist in accessing services and managing side effects.

In terms of predisposing factors, individual-level psychosocial elements such as knowledge, attitudes, emotions, and beliefs regarding FP/RH behaviors play a crucial role in decision-making. These factors are deeply influenced by social and gender norms, impacting individuals' perceptions of control and ability to access skilled care. Misinformation, fear, mistrust, and lack of supportive perceptions regarding social norms contribute to low adoption of health-promoting behaviors.

Reinforcing factors, including relationships with spouses, family, friends, and community members, significantly shape individual predispositions towards FP/RH behaviors. Misplaced trust, resistance from influencers, inadequate support, and stigma surrounding certain behaviors hinder the adoption of health-promoting practices. Additionally, institutional factors such as gender-sensitive values among decision-makers and insufficient motivation to prioritize FP/RH issues further contribute to these challenges. Enabling factors encompass various facilitating elements related to the availability, accessibility, affordability, and quality of services tailored to individuals' needs. Lack of accessible services, poor quality of care, inadequate counseling skills among providers, and limited community involvement are significant barriers to creating an enabling environment for FP/RH. Addressing these factors is essential for promoting behavior change and improving health outcomes in Punjab.

This strategy document outlines a ***Multi-Pronged Strategy*** aimed at promoting healthy decision-making and behavior change related to FP/RH across various levels of influence, including audiences at the household, community, and institutional, who have strong influences in shaping individual behaviors related to FP/MNCH. With PPFP and PAFP as a priority thematic focus, each strategy is aimed at promoting a behavioral outcome for a specific audience at each level, including:

1. ***INDIVIDUALS:*** Married women of reproductive age (MWRA) & Married men
2. ***HOUSEHOLDS:*** Husbands and Mothers-in-law
3. ***COMMUNTIY:*** Religious leaders, Community leaders, community activists, and peers
4. ***SERVICE DELIVERY:*** Facility and community-based health care providers
5. ***INSTITUTIONAL & POLICY:*** Decision makers and Influencers

Strategy 1 focuses on nurturing personal skills and agency among married women and men of reproductive age to address predisposing factors hindering the adoption of target behaviors. By enhancing individual knowledge, attitudes, and perceptions of social norms, this strategy aims to increase demand for FP/RH information and services while also promoting the adoption of male family planning methods.

The interventional approach for women's and men's FP/RH behaviors employs a range of strategies to engage individuals and promote behavior change. For women, particularly those in rural and peri urban areas the primary mode of engagement will be community-based health education through household visits and neighborhood meetings, while also claiming community and social spaces with women-focused messaging through community-based health promotion, and augmented by mass media and social media campaigns, community signposting, and social media engagement are utilized alongside efforts to improve knowledge and skills regarding target behaviors and reduce environmental constraints through strengthened referral systems and provision of family planning services through private sector using social marketing and clinical franchising in LHW uncovered areas supported by voucher schemes for BISP beneficiaries.

Similarly, for men, a multi-faceted approach involving community engagement, mass media strategies, and SMS-based campaigns is

employed to drive behavior change and enhance access to FP services. Both approaches aim to empower individuals, facilitate informed decision-making, and improve reproductive health outcomes for families.

Strategy 2 seeks to transform social and gender norms within households, communities, and institutions to reinforce individual agency, and facilitate behavior change. By promoting enhanced interspousal communication, shared decision-making, and supportive social and gender norms, this strategy aims to create an environment conducive to healthier behaviors and increased male engagement in FP/RH.

The intervention approach aims to engage families, Community Popular Opinion Leaders (CPOLs), and government office bearers (OBs) as allies supporting behavior change for male involvement in FP/RH and interspousal communication. Movement building using validated key messages, tailored IEC materials, a resource book for norm shifting advocates, and identifying societal influencers. Regular events and dialogues are organized to galvanize support and advocacy. Community and media partnerships amplify the endorsement of societal influencers, utilizing public service messages, call-in talk shows, high-visibility media coverage, male engagement events, and inter-generational dialogues to promote adoption of target behaviors. These initiatives seek to foster a supportive environment for family planning and gender equality at the individual, household, and community levels.

Finally, ***Strategy 3 focuses on promoting institutional and structural factors*** that enable healthy decision-making by strengthening community-led social action, enhancing provider behavior change for delivering high-quality care, and improving stewardship efforts to enhance the availability and utilization of FP/RH services. By improving system responsiveness and fostering community ownership, this strategy aims to streamline access to FP/RH services while ensuring dignified and respectful care delivery. Through these interconnected strategies, this strategy aims to create sustainable behavior change and promote positive norms surrounding FP/RH across Punjab.

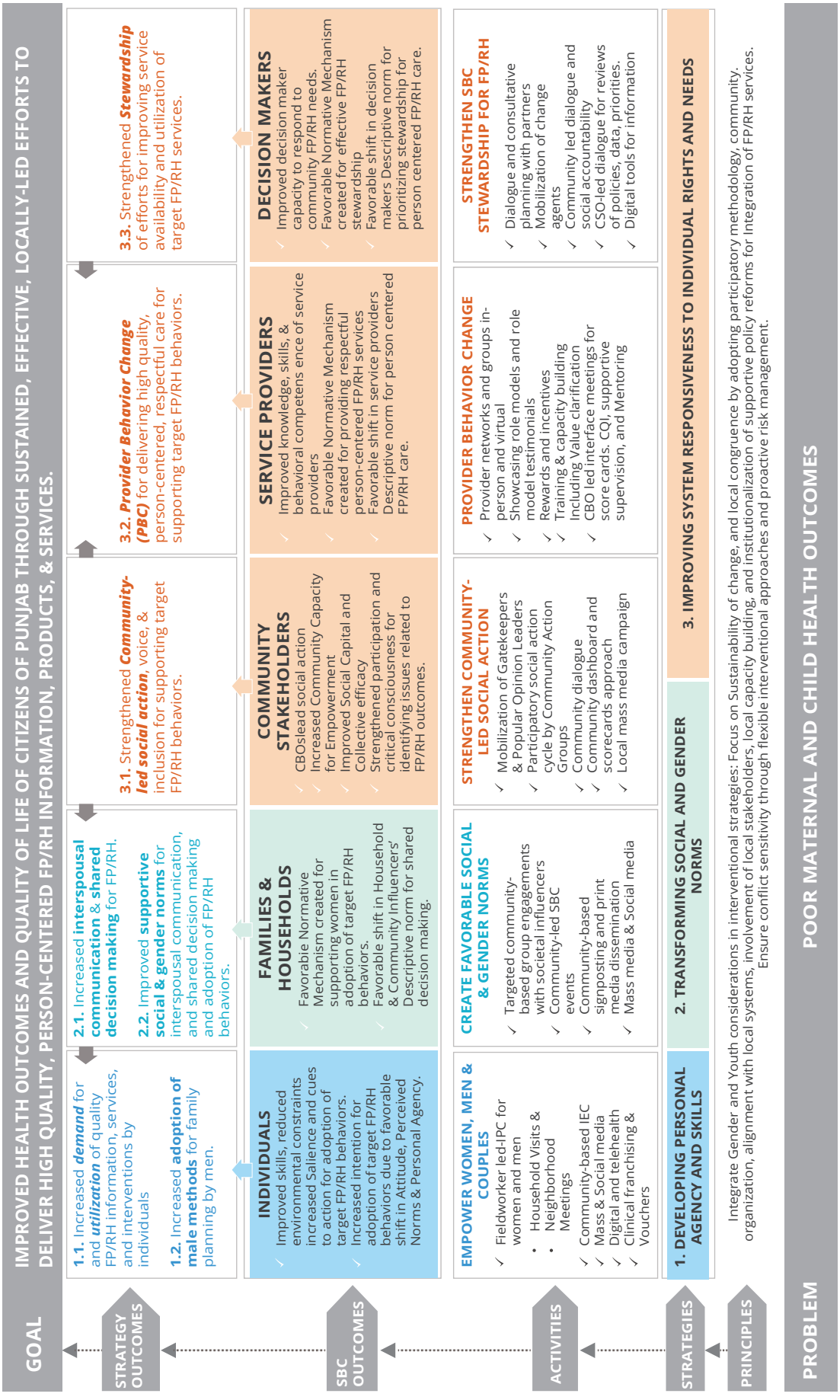
The intervention approach for community-led social action focuses on promoting local ownership and participatory health education principles, targeting critical consciousness building, social capital enhancement, and community empowerment. This strategy entails three steps: building critical consciousness and facilitating issue selection, followed by building social capital and enhancing collective efficacy, and finally supporting community capacity and facilitating empowerment. Activities include community dialogues, capacity building workshops, co-design sessions for social accountability, and community action planning. The goal is to empower communities to identify and address priority FP/RH issues through social action while engaging decision makers and influencers through advocacy efforts. Additionally, for improving institutional stewardship, the strategy plans to leverage social advocates and dialogues to promote favorable norms and advocate for policy changes supporting gender-responsive FP/RH services, backed by activities such as community-led dialogues, co-design workshops, and mass media campaigns. These comprehensive approaches aim to strengthen community engagement, enhance institutional stewardship, and promote positive behavior change for improved reproductive and maternal health outcomes.

All strategies are accompanied by youth and gender considerations for guiding the development of interventional approaches. The implementation approach for enhancing SBC for FP/RH in Punjab revolves around a systematic collaboration between the public and private sectors, guided by a five-phase framework. Phase 1 focuses on strengthening stewardship through the establishment of a Family Planning SBC Working Group and

developing a comprehensive activity roadmap. Phase 2 emphasizes establishing sustainable funding mechanisms to support multi-level SBC approaches, diversifying funding sources, and promoting synergy among stakeholders. Phase 3 involves co-creating activity designs and validating SBC materials to address existing gaps. Phase 4 entails implementing the SBC strategy and monitoring progress through regular data reviews and quarterly progress meetings. Finally, Phase 5 underscores evidence-driven decision-making by establishing evaluation mechanisms to assess the impact of interventions and refine strategies, ultimately promoting healthier reproductive practices and informed decision-making among citizens of Punjab.

A plan for Monitoring, Evaluation and Learning (MEL) has also been developed guided by the theories of change and strategy interventions along with descriptions of key learning questions, measurement domains and source of data aligned with the overarching results framework for the strategy is presented in Figure 1 and an initial timeline of activities, outputs and associated costing estimated are presented in Annex 2, consolidated costs by strategy are presented in Annex 3, and costing by channel and medium is presented in Annex 4.

Figure 1: SBC Strategy for FP/RH in Punjab - Results Framework



Introduction

This document describes a comprehensive Social and Behavior Change (SBC) Strategy for promoting the adoption of family planning in Punjab. It presents a detailed needs assessment and behavior analysis, a comprehensive, integrated SBC Framework for the strategy, an implementation framework, and a multilevel SBC strategy to boost the utilization of services for family planning in Punjab. This ***SBC strategy document*** has been conceptualized to serve as a ***technical resource*** capable of serving as ***input material*** to guide the ***co-creation of operational plans***. This also includes the collaborative development and validation of key resources and materials, and facilitating collaborative implementation, monitoring, and evaluation of the SBC strategy by stakeholders and development partners across districts of Punjab.

Why an SBC Strategy

Behavior change research has posited that increasing only knowledge and awareness of healthy behaviors is not adequate to lead to sustained behavior change. Larger social determinants influence people's ability to deliberate, decide, attempt, practice, and then sustain various behaviors that have an impact on health. Along with systemic and contextual factors, health outcomes are influenced by behaviors of individuals, households, health care providers, schoolteachers, religious and community leaders, and policymakers.

For effective SBCC interventions which produce sustained social and behavior change, programs need to consider core SBC principles (Figure 2) and adopt a systematic approach to identifying contextually relevant, culturally congruent, and evidence-based strategies that are linked to theory-driven, measurable behavior change outcomes.

01 **Section 1** of the document presents a contextually informed statement of need along with a behavioral diagnosis for family planning behaviors in the province.

02 **Section 2** presents the integrated SBC Framework with a description of the theory of change for changing behaviors of priority audience segments at different levels, and the implementation framework.

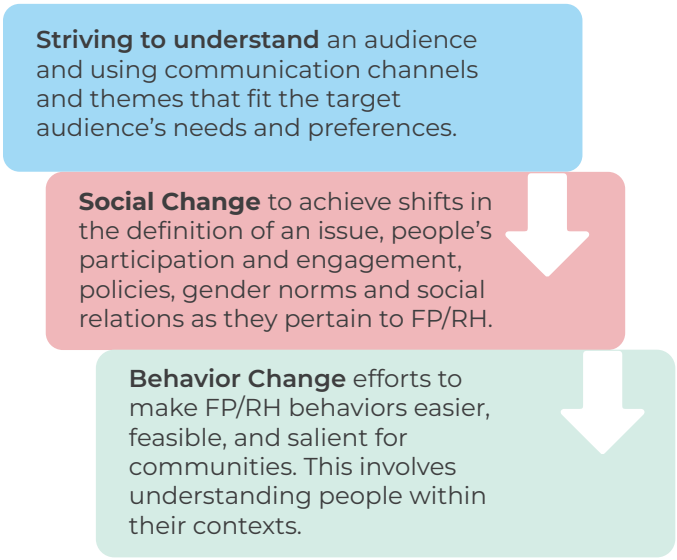
03 **Section 3** presents a description of strategies and SBC interventional modalities segmented by audiences.

04 **Section 4** presents a plan for monitoring and evaluation of the strategy.

Systemic Challenges and Strategic Considerations for Sustainability

The sustainability and effectiveness of SBC initiatives for family planning and reproductive health in Punjab are challenged by several systemic issues. These include fragmented stewardship, which hampers cohesive leadership and coordination, resulting in limited synergies across investments. This not only reduces the potential for collaborative interventional impact, but also adversely affects the effectiveness of SBC initiatives by increasing the noise and cognitive burden experienced by target audiences. SBC efforts are also constrained by limited, time-bound funding, making it difficult to sustain long-term initiatives. Competing priorities among stakeholders also divert focus and

Figure 2: Core Principles for SBC Strategy Development



resources away from SBC activities. Furthermore, there is a limited application of technical knowledge, hindering the effectiveness of the interventions and effectively reducing SBC to mere knowledge dissemination. Lastly, the lack of evidence and data on SBC further restricts the ability to measure impact and refine strategies based on rigorous evidence. These challenges collectively undermine the potential success of SBC efforts in the region. This strategy has been conceptualized with a view to addressing these specific challenges which have a direct impact on the sustainability potential for SBC programming for family planning in the Punjab.

The strategy has been meticulously designed to address systemic challenges and enhance the sustainability of SBC efforts for family planning and reproductive health in Punjab, extending its impact beyond the current funding period. Central to this strategy is the establishment of a robust, theory-informed technical foundation for SBC programming. This foundation will serve as a critical resource for stakeholders across the public, development, and private sectors, guiding investments and ensuring that all interventions are grounded in sound technical principles.

Furthermore, the strategy is crafted to be dynamic, adaptable, and inclusive, fostering a collaborative environment for the co-creation and co-design of SBC interventions and investments throughout Punjab. This approach not only encourages broad stakeholder participation but also ensures that the strategy remains responsive to changing needs and priorities. A key feature of the strategy is its phased approach to the collaborative development of costed implementation plans, which includes a focus on identifying and addressing funding gaps beyond current financial allocations. This strategic focus will highlight areas where additional investments may be needed potentially through donor funding and development partnerships.

The strategy also emphasizes the importance of leveraging existing systems, structures, and resources, while collating critical learnings from the SBC space during the selection of intervention channels with a view to informing low-cost, high-yield SBC initiatives. These initiatives will not only strengthen existing channels for audience engagement but will also facilitate the rapid development, operationalization, and deployment of interventions. Through these elements, the strategy is poised to overcome some of the existing, foundational challenges and improve long-term sustainability potential and effectiveness of SBC efforts for family planning and reproductive

health in Punjab.

Methodology for SBC Strategy Development

This SBC Strategy was developed iteratively, guided by a review of existing quantitative data on key health behaviors, desk review of published evidence and recent learnings in the SBC space, a review of existing records and action plans pertaining to SBCC, and an extensive consultative review process with key stakeholders in Punjab, guided by an established strategic planning framework for health promotion.

Strategic Planning Framework

Green & Kreuter's PRECEDE-PROCEED Model1 was used to guide the strategic planning process for SBC focusing on FP/MNCH. The PRECEDE–PROCEED Model is the most widely used cost–benefit evaluation framework that can help health program planners, policy makers and other evaluators analyze situations and design comprehensive health focused SBC programs efficiently. It provides a comprehensive structure for assessing health and quality of life needs, and for designing, implementing and evaluating health promotion programs to meet those needs. The model is multidimensional and is founded in the social/behavioral sciences, epidemiology, administration, and education. Systematic use of the framework since its introduction confirms the utility and predictive validity of the model as a planning tool. A prime purpose and guiding principle of the PRECEDE–PROCEED model is to direct initial attention to outcomes, rather than inputs. It guides planners through a process that starts with desired outcomes and then works backwards in the causal chain to identify a mix of strategies for achieving those objectives. A fundamental assumption of the model is the active participation of its intended audience — that is, that the participants will take an active part in defining their own problems, establishing their goals and developing their solutions. In this framework, health behavior is regarded as being influenced by individual, social, and environmental factors which are accounted for in this strategy and presented in Figure 4.

Strategic Planning Process

The SBC strategy development process was led by PWD, in consultation with the Technical Working Group (TWG) on DLR 4.1 of Punjab Family Planning Programme (PFPP), notified by GoPb in October 2023. Table 1 presents an overview of this iterative process along with methods used to inform each step of the process. For a detailed listing of stakeholders consulted please see Annex 1.

In **March 2024,** the scope of work and technical assistance needs for preparing SBC Strategy for the Punjab Family Planning Program were defined through a consultative meeting with the Technical Working Group (TWG) for PFPP DLI 4.1, involving engagement with different line departments and stakeholders and confirming decisions on scope of the strategy, next steps, and timelines.

In **April 2024**, the 1st Draft of the SBC Strategy for FP/MNCH Punjab was developed. This version leveraged learnings from the Rapid Landscape Assessment of Existing Health System and Key System Strengthening Partners for SBCC for PPFP and PPFP conducted by Pathfinder International under the BMGF supported Qadam-ba-Qadam (QBQ) PPFP Project in 2023 and focused on

developing a robust technical foundation for the strategy in alignment with established recommendations for SBC and by applying recommended frameworks pertinent to the scope of the strategy. This draft was reviewed and presented to the TWG for feedback and consultation, leading to the 2nd Draft later in the month, which included strategy descriptions, audience segmentation, communication and engagement objectives, and interventional mapping by objective.

In **May 2024**, the 3rd Draft incorporated an implementation framework and mapping of activities to specific interventions, following feedback from the TWG, PFPP, IRMNCH & NP, and the World Bank. By the end of May, the 4th Draft, revised with stakeholder and World Bank feedback, was circulated for final review.

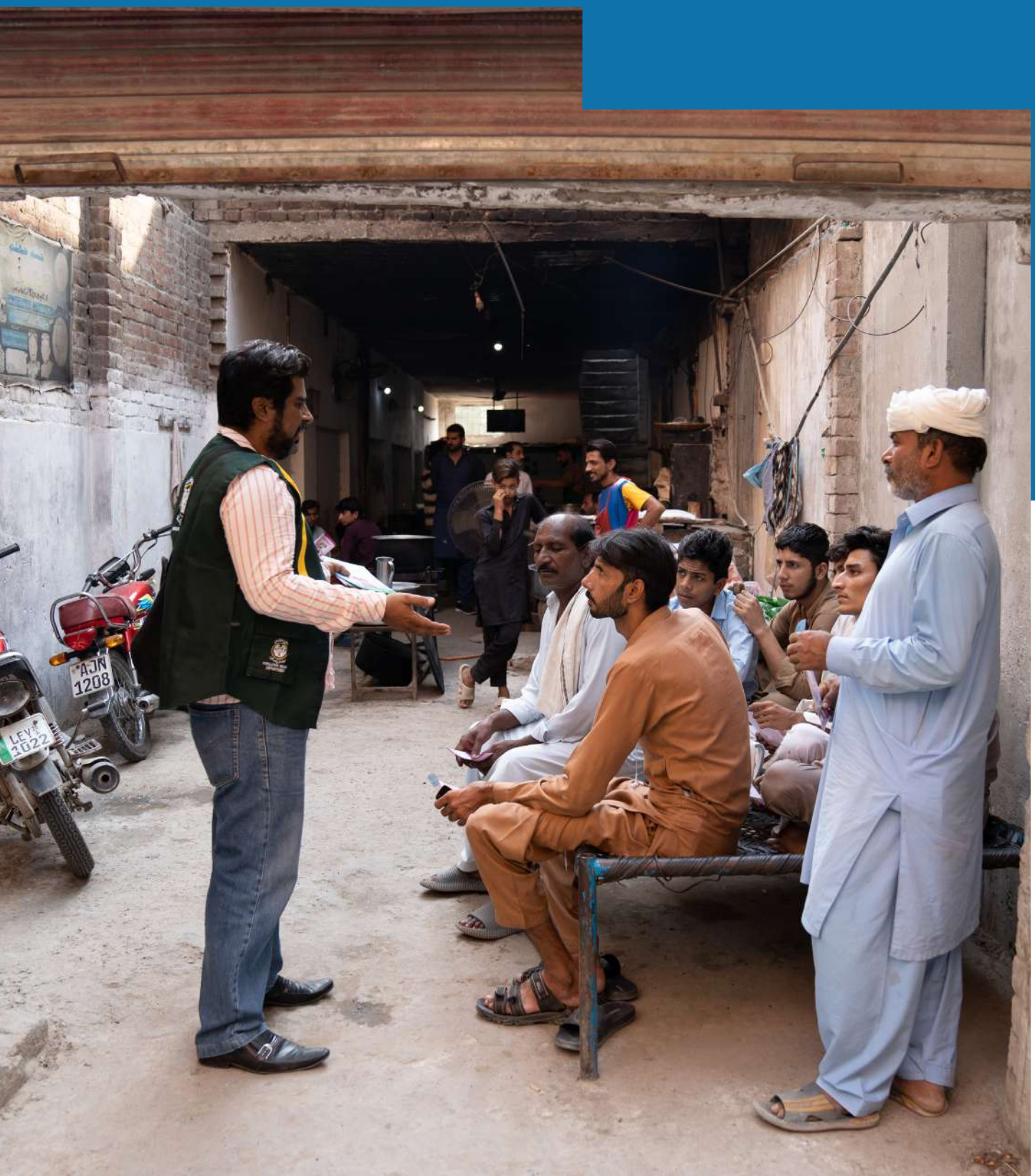
In **July 2024**, the SBC Strategy was finalized, incorporating preliminary implementation plans and financial outlays, and ensuring alignment with both short-term and long-term implementation objectives, after thorough consultations and feedback integration from stakeholders and the World Bank.

Table 1: SBC Strategy Development Process and Methods

Date	Output	Methods
22 Jun 2023	• Rapid Landscape Assessment of Existing Health System and Key System Strengthening Partners for SBCC for PPFP and PPFP	• Key Informant Interviews • Desk Review • Review of Records
20 Mar 2024	• Scope of work and technical assistance needs for preparation of Social Behavior Change (SBC) Strategy for the Punjab Family Planning Program. • Engagement of relevant departments and stakeholders. • Decision on scope, timelines and next steps.	• Consultative Meeting of TWG for PFPP DLI 4.1.
2 Apr 2024	• 1st Draft of the SBC Strategy for FP/MNCH Punjab including Key Gaps and Challenges to address; technical approach and framework	• Desk review of existing data on key health behaviors • Desk review for published evidence on behavioral drivers for priority behaviors • Draft 1 was presented to TWG for PFPP DLI 4.1. • Feedback and consultation for alignment and next steps

Date	Output	Methods
22 Apr 2024	• 2nd Draft of the SBC Strategy for FP/MNCH Punjab including strategy descriptions along with audience segmentation, communication and engagement objectives, and Interventional mapping by objective	• Review of current SBCC action plans for PWD Punjab • Incorporation of feedback received from TWG on Draft 1. • Draft 2 presented to TWG for PFPP DLI 4.1. • Feedback and consultation for alignment and next steps
13 May 2024	• 3rd Draft of the SBC Strategy for FP/MNCH Punjab including in addition to above, implementation framework, and mapping of activities to specific interventions	• Incorporation of feedback received from TWG on Draft 2. • Draft 3 presented to PFPP, IRMNCH & NP • Feedback provided, review of comments received from World Bank, and consultation for scope of revisions
31 May 2024	• 4th Draft of the SBC Strategy for FP/MNCH Punjab	• Incorporation of feedback received from stakeholders and World Bank reviewers on Draft 3. • Revised strategy document circulated to stakeholders and World Bank for final review and comments.
8 Jul 2024	• 5th Draft of the SBC Strategy for FP/MNCH Punjab revised to include preliminary action plans and financial outlays, and alignment with implementation plans, in the short term and long term.	• Review of comments received from World Bank • Consultation for scope of revision with stakeholders • Incorporation of feedback received from stakeholders and World Bank on Draft 4.
13 Aug 2024	• SBC Strategy for FP/MNCH Punjab – final version for consultative action planning.	• Review of comments received from World Bank and stakeholder consultation for scope of revision • Rapid desk review for supporting evidence. • Incorporation of feedback received on Draft 5

Section 1



Diagnosis – Understanding the Situation

Pakistan is the fifth most populous country in the world with a population of 241.49 million[2]. People aged 0-14 years comprise 39.98%, 15-64 years comprise 56.65%, and aged 65 and above make up 3.36% of the total population, Pakistan has a higher proportion of males than females, the percentage of the female population is 48.98% compared to 51.02% male population.[2] Pakistan is poised for continued population expansion, projected to reach 403 million by 2050.[3]

According to PDHS 2017-2018, the Total Fertility Rate (TFR) in Pakistan is 3.6 births per woman, which is 3.9 in rural and 2.9 in urban areas. Between 2012-13 and 2017- 18 a reduction of 0.3 births per woman was observed in both urban and rural areas. However, there is a desire to limit pregnancies only after a woman has had at least four children, (mean ideal number of children of 3.9 for women and 4.3 for men). Additionally, the contraceptive discontinuation rate for Pakistan is also increasing with 3 out of 10 contraceptive users discontinuing use within 12 months of starting; and the proportion of women who intend to use family planning has been decreasing from 50% in 2006-07, to 39% in 2012-13, and to 33% in 2017-18.[5]

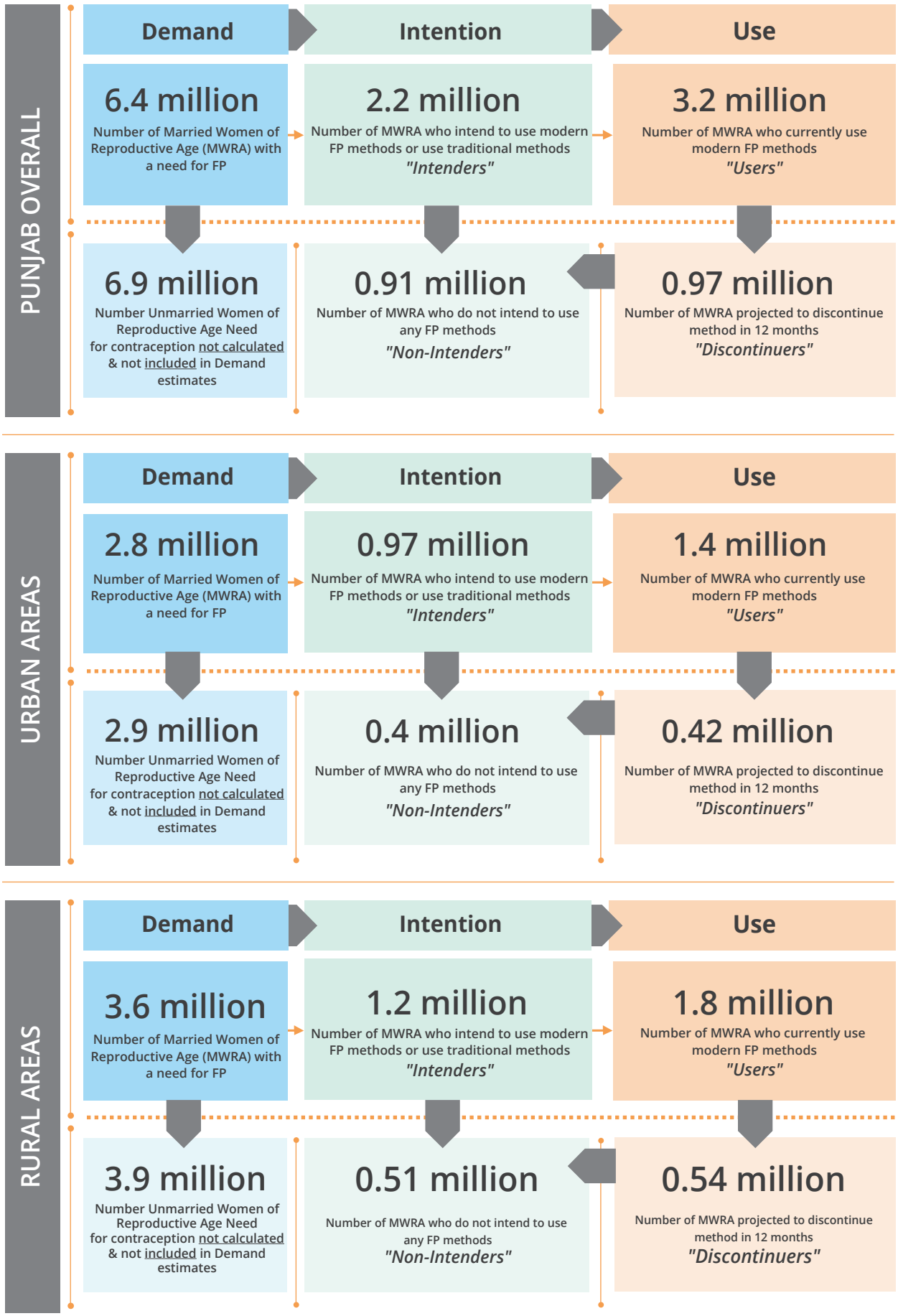
Family Planning in Need and Use in Punjab

The total demand for family planning in Punjab is significantly under-served, with an estimated 6.4 million Married Women of Reproductive Age (MWRA) with a need for family planning. Currently, around 50% of this total need in Punjab is met through modern contraceptive methods, leaving approximately 3.2 million MWRA currently using a modern method. Of these, 1.4 million users live in urban areas, and 1.8 million reside in rural Punjab.

Of the 6.4 million MWRA in Punjab (2.8 million in urban areas, and 3.6 million in rural areas) with a need for family planning, 2.2 million (0.97 million in urban areas, and 1.2 million in rural areas) intend to use family planning in the future, demonstrating an existing latent demand for family planning services. However, a significant gap remains, with over 900,000 MWRA (0.97 million in urban and 1.2 million in rural areas) expressing no intention to use any contraceptive methods. Additionally, 966,200 women (0.42 million in urban and 0.54 million in rural areas) are projected to discontinue the use of contraceptive methods within 12 months of adopting a method.

Data from the PDHS 2017/18 reveal that an astounding 6.9 million women of reproductive age (2.9 million in urban areas, and 3.9 million rural areas) who are not currently married are not accounted for in the current contraceptive need estimates, highlighting a considerable underestimation of the total family planning needs in the province. Figure 3 presents an overview of the use-need estimates for Punjab.

Figure 3: Need and Use for Family Planning in Punjab



Socio-Demographic Landscape in Punjab

In Punjab, Pakistan's largest province, the population stands at approximately 127.7 million.[2] The gender distribution shows roughly 61.1 million males and 58.4 million females, indicating a nearly equal ratio.[2] Urban areas are home to around 48 million people, while rural regions accommodate approximately 70 million residents.[2] The average age of the population is 27 years, reflecting a predominantly youthful demographic profile. These statistics depict Punjab as a diverse and dynamic province with a significant mix of urban and rural inhabitants, characterized by a considerable youth population.[6]

Wide disparities exist in ***socio-economic status***, with greater levels of poverty in rural areas, compared to urban areas of the province. In Punjab, the lowest quintile comprises 13.1% of the population, while the highest quintile constitutes 20.5%.[5] Urban regions show a concentration of wealth, with the lowest quintile at 1.0% and the highest at 49.6%.[5] Conversely, rural areas exhibit higher proportions in the lowest quintile (18.6%) and lower in the highest (7.2%).[5] These findings highlight disparities, necessitating targeted interventions for equitable economic development.

Table 2: Socioeconomic Profile of Punjab - % distribution across wealth quintiles by residence

	Lowest (%)	Second (%)	Middle (%)	Fourth (%)	Highest (%)
Punjab	13.1	19.2	23.5	23.7	20.5
Urban	1.0	2.7	15.7	31.1	49.6
Rural	18.6	26.8	27.1	20.4	7.2

Educational attainment in Punjab varies across different stages and demographic groups, as indicated by the percentages of the population reaching various levels of education. [5]

Table 3: Educational Attainment in Punjab - % distribution of highest level of education, by sex and residence

	No education (%)		Primary (%)		Middle (%)		Secondary (%)		Higher (%)	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Punjab	38.1	20.6	20.7	22.5	11.5	18.9	14.1	23.2	15.5	14.9
Urban	19.6	12.1	19.3	21.7	14	18.4	20.9	28	26.2	19.8
Rural	48.6	26.2	21.6	23	10.1	19.2	10.2	20	9.5	11.6

A notable portion of the population has achieved primary and secondary education, with fewer individuals reaching higher education. Specifically, 38.1% of women and 20.6% of men have no education, while 20.7% of women and 22.5% of men have completed primary education. Middle education is attained by 11.5% of women and 18.9% of men, secondary education by 14.1% of women and 23.2% of men, and higher education by 15.5% of women and 14.9% of men.[5]

Examining ***educational attainment by residence*** reveals stark disparities between urban and rural areas. In urban regions, 19.6% of women have received no education, compared to rural areas, where nearly half (48.6%) of all women in rural areas have not received any education.[5] In urban areas, a lower percentage of individuals have no education compared to rural areas. Specifically, 19.6% of urban women and 12.1% of urban men have no education, whereas in rural areas, these figures rise to 48.6% for women and 26.2% for men. Urban residents have higher percentages of individuals completing higher education, with 26.2% of urban women and 19.8% of urban men achieving this level, compared to 9.5% of rural women and 11.6% of rural men.[5] Primary, middle, and secondary education levels are relatively balanced between urban and rural areas but with a slight edge towards urban residents. This urban-rural gap highlights differences in access to educational resources and opportunities, with urban areas typically offering better educational facilities and infrastructure.

Furthermore, when considering ***educational attainment by gender***, the data show significant gender disparities in educational attainment. In Punjab, women are more likely to have no education compared to men, with 38.1% of women and 20.6% of men falling into this category.[5] Men generally attain higher education levels more frequently than women. For instance, 23.2% of men have completed secondary education compared to 14.1% of women, and 14.9% of men have attained higher education compared to marginally higher 15.5% of women.[5] While primary and middle education levels show less disparity, men still lead with 22.5% having completed primary education compared to 20.7% of women, and 18.9% completing middle education compared to 11.5% of women.[5]

This indicates that, on average, women have lower educational attainment compared to men in the region. Addressing this gender disparity in education is crucial for promoting gender equality and ensuring that women have equal access to educational opportunities and resources. Efforts to enhance educational access and quality, particularly for women in rural areas, are essential for fostering inclusive and equitable development in Punjab.

Maternal and Child Health Outcomes

A clear need for health system interventions is indicated by a comparison of key health outcome indicators between Punjab and the national averages for Pakistan. Punjab demonstrates a maternal mortality ratio (MMR) at 157 per 100,000 live births and neonatal mortality rate (NMR) at 41 per 1000 live births[7] which is comparable to the national average of MMR at 154 per 100,000 live births, and NMR at 42 per 1000 live births[8].

However, Punjab exhibits a notably higher infant mortality rate (IMR) and under 5 mortality rate at 77 and 93 deaths per 1000 live births[7] respectively, compared to the national averages of IMR at 53 and under 5 mortality rate at 67 deaths per 1000 live births[8]. Addressing these gaps requires targeted interventions to empower women and improve reproductive and child health services, especially in rural areas.

Table 4: Maternal and Child Health Outcomes in Punjab, compared to national average

	Punjab	National Average
Maternal Mortality Ratio	157	154
Neonatal Mortality Rate	41	42
Infant mortality rate /1000 live births	77	53
Under 5 Mortality Rate / 1000 live births	93	67

Fertility

The overall total fertility rate (TFR) for Punjab stands at 3.7 children per woman, with urban areas exhibiting a slightly lower TFR of 3.2 compared to rural regions with a TFR of 4.0.[5] This disparity between urban and rural TFRs suggests varying reproductive behaviors and potentially distinct socio-economic factors influencing family planning practices within these settings.

Table 5: Total Fertility Rate and Adolescent Birth Rate in Punjab, by residence

	Total Fertility Rate	Adolescent Birth Rate (per 1000 females)
Punjab	3.7	40
Urban	3.2	32
Rural	4.0	44

Additionally, the adolescent birth rate (ABR) presents notable differences, with an overall ABR of 40 births per 1000 females aged 15-19 years in Punjab. Urban areas report a lower ABR of 32, contrasting with rural areas recording a higher ABR of 44 suggesting a high unmet need among adolescents and youth.[5] This divergence underscores the need for targeted, age appropriate and culturally congruent interventions and reproductive health education programs for adolescents and youth, regardless of marital status, particularly in rural areas, to address the specific challenges and vulnerabilities associated with adolescent pregnancies and maternal health outcomes.

Overall, the data delineates crucial patterns in fertility dynamics across urban and rural divides in Punjab, guiding policymakers, and healthcare practitioners in formulating effective strategies to address reproductive health disparities and promote equitable access to family planning services.

Demand & Unmet Need for Family Planning

Overall, in Punjab 57.2% of the demand for family planning is satisfied with modern methods, with urban regions demonstrating a slightly higher rate at 58.6% compared to rural areas at 56.3%.[9] At the divisional level, considerable disparities in the percentage of demand satisfied with modern methods are observed. For instance, Multan division reports the highest rate at 67.6%, indicating a relatively higher uptake of modern contraceptive methods in this region.[9] Conversely, Gujranwala division exhibits the lowest rate at 44.8%, suggesting greater challenges in meeting the demand for family planning with modern methods in this division.[9]

Table 6: Total demand, unmet need, and met need for FP in Punjab, by residence and division

	Unmet need for family planning			Met need for family planning (currently using contraception)			Total demand for family planning			Percentage of demand for family planning satisfied with:	
	For spacing births	For limiting births	Total	For spacing births	For limiting births	Total	For spacing births	For limiting births	Total	Any method	Modern methods
Punjab	8.9	8.9	17.8	9.7	24.6	34.4	18.6	33.6	52.2	65.8	57.2
Urban	9.2	8.8	18.1	11.0	26.6	37.6	20.2	35.5	55.7	67.5	58.6
Rural	8.7	9.0	17.7	9.0	23.4	32.5	17.7	32.4	50.2	64.7	56.3
Division											
Bahawalpur	7.2	7.1	14.3	11.5	27.2	38.7	18.6	34.3	52.9	73.1	65.8
D. G. Khan	10.3	10.6	20.9	6.8	18.9	25.7	17.1	29.4	46.6	55.1	51.2
Faisalabad	8.1	6.2	14.3	11.6	27.5	39.1	19.6	33.7	53.4	73.2	58.7
Gujranwala	11.8	11.2	23.0	6.5	20.0	26.6	18.3	31.2	49.6	53.6	44.8
Lahore	9.1	9.6	18.8	11.3	26.6	38.0	20.5	36.3	56.8	66.9	59.0
Multan	5.9	6.0	11.9	11.4	30.4	41.8	17.3	36.5	53.7	77.9	67.6
Rawalpindi	10.3	11.3	21.6	11.0	20.4	31.4	21.3	31.7	53.0	59.3	53.7
Sahiwal	8.1	7.3	15.4	8.6	25.7	34.3	16.7	33.0	49.6	69.0	61.6
Sargodha	8.1	10.5	18.6	7.9	23.6	31.5	15.9	34.1	50.0	62.9	53.7

Overall, Punjab exhibits an unmet need for family planning of 17.8%, with both spacing and limiting births contributing equally at 8.9%.[9] When disaggregated by urban and rural areas, urban regions demonstrate a slightly higher unmet need at 18.1%, compared to rural areas at 17.7%.[9] At the divisional level, variations in unmet need are evident. For instance, Dera Ghazi Khan division reports the highest unmet need at 20.9%, with both spacing and limiting births contributing significantly at 10.3% and 10.6%, respectively.[9] Conversely, the Multan division exhibits the lowest unmet need at 11.9%, with a relatively lower proportion of individuals expressing a desire to either space or limit births. [9]

Family Planning Behaviors

The modern Contraceptive Prevalence Rate (CPR) data for Punjab, Pakistan, delineates notable disparities between urban and rural areas as well as among divisions within the province. In urban regions, the CPR stands at 32.6%, indicating a higher acceptance and utilization of modern contraceptive methods among women of reproductive age.[9] Conversely, rural areas exhibit a slightly lower CPR of 28.2%, suggesting a marginally lower prevalence of modern contraceptive usage among rural women compared to their urban counterparts.[9] Among the divisions within Punjab, Bahawalpur demonstrates the highest CPR at 34.8%, while Dera Ghazi Khan records the lowest at 23.9%. Noteworthy variations exist across divisions, with Multan (36.3%) and Lahore (33.5%) displaying relatively high CPRs, whereas Gujranwala (22.2%) and Sargodha (26.9%) divisions depict lower rates of modern contraceptive prevalence. [9]

Table 7: Contraceptive Prevalence Rate (CPR), overall % and by divisions and method

	No Method	Long-Acting Reversible Methods		Short Term Methods					Permanent Methods		(LAM)	Traditional Methods
		IUD	Implants	Injectables	Pill	Male condom	Female condom	Diaphragm/ Foam/Jelly	Female sterilization	Male sterilization		
Punjab	65.6	2.9	0.3	2.8	1.6	11.8	0.3	0.5	8.3	0.1	1.3	4.5
Urban	62.4	2.4	0.4	1.8	1.4	15.7	0.3	0.5	8.6	0.1	1.2	5.0
Rural	67.5	3.1	0.3	3.3	1.7	9.6	0.3	0.4	8.1	0.1	1.4	4.2
Division												
Bahawalpur	61.3	4	0.4	4.1	1.5	11.6	0	0.9	9.8	0.3	2.3	3.8
D. G. Khan	74.3	3.8	0.3	5.4	1.9	5.7	0.1	0.2	5.3	0.2	0.9	1.8
Faisalabad	60.9	2.8	0.2	1.9	1.4	13.3	0.1	0.1	10.6	0.2	0.8	7.7
Gujranwala	73.4	2.0	0.3	1.7	1.1	9.1	0.8	0.4	6.4	0.0	0.4	4.3
Lahore	62.0	2.7	0.3	1.2	1.0	16.6	0.4	0.8	8.4	0.1	1.9	4.5
Multan	58.2	3.0	0.3	3.3	2.2	10.8	0.1	0.6	12.6	0.1	3.4	5.5
Rawalpindi	68.6	2.2	0.5	4.7	2.0	13.4	0.5	0.4	4.3	0.1	0.5	2.9
Sahiwal	65.7	3.1	0.2	1.9	1.2	12.9	0.1	0.6	10.0	0.1	0.4	3.6
Sargodha	68.5	3.2	0.5	2.8	2.4	10.6	0.1	0.1	6.6	0.1	0.5	4.5

The data on CPR disaggregated by method and geographic divisions reveals variations in contraceptive usage patterns across Punjab. Overall, Punjab exhibits a CPR of 65.6%, with rural areas recording a slightly higher CPR of 67.5% compared to urban areas at 62.4%.[9] When examining the distribution of contraceptive methods, long-acting reversible contraceptives (LARCs) are utilized by 2.9% of the population, with rural areas demonstrating a slightly higher usage rate of 3.1% compared to urban areas at 2.4%.[9] Short-term methods are utilized by 15.7% of the urban population and 11.8% of the rural population, indicating a higher preference for short-term methods in urban areas.9 Permanent methods are utilized by 8.6% of the urban population and 8.3% of the rural population, demonstrating relatively similar usage rates across urban and rural settings.[9] Additionally, traditional methods are utilized by 5.0% of the urban population and 4.5% of the rural population, with urban areas exhibiting a slightly higher usage rate of traditional methods compared to rural areas.[9]

The divisional analysis reveals further disparities in contraceptive method usage within Punjab. For instance, Dera Ghazi Khan division exhibits the highest proportion of individuals not using any contraceptive method at 74.3%, with a notable preference for short-term methods (5.4%) and male sterilization (0.9%).[9] In contrast, Lahore division demonstrates a relatively lower proportion of individuals not using any method at 62.0%, with a higher utilization of long-acting reversible contraceptives (2.7%) and male condoms (16.6%).[9] These variations in contraceptive method preferences highlight the importance of tailored interventions and targeted family planning programs to address the diverse needs and preferences across different geographic divisions within Punjab.

POST PREGNANCY FAMILY PLANNING – A MISSED OPPORTUNITY IN PUNJAB

Post-pregnancy family planning (PpFP), including postpartum family planning (PPFP) and postabortion family planning (PAFP), is an evidence-based, high impact practice (HIP) with demonstrated potential for significantly improving the mCPR and reducing the unmet need for family planning.[10,11,12,13,14]

According to the PDHS 2017-18, couples' desire for another child decreases with the birth of each child, however, the adoption of PPFP in Punjab, remains low with less than a third of women adopting a modern contraceptive method in the post-partum period.[5,10,13]

This is not surprising given that less than 20% of women who deliver at a facility are counseled, or even informed about family planning methods. Similarly, an alarmingly low proportion (16-17%) of women delivering at public or private sector facilities are guided where to get family planning or counselled on family planning before leaving the facility post-delivery.[9]

According to last available estimates, of the 5.1 million annual pregnancies in Punjab, an estimated 47% are unintended pregnancies. Of these, 54% are managed through induced abortions, while 12% result in miscarriages. These estimates underscore that annually there are over 3.4 million women in the province with an indicated need for PAFP.[15] While reliable data on PAFP rates in the province, are not readily available, current evidence suggests that uptake of long-term PAFP remains low.[16]

These data highlight substantial gaps in integration of PPFP and PAFP services in secondary, tertiary, and specialized centers, and Punjab can leverage this missed opportunity to integrate high quality counselling in RH service delivery platforms to enhance uptake of PPFP/PAFP by women who deliver in health facilities.

Access to Family Planning Counseling and Services

The data on family planning barriers in Punjab highlights challenges in accessing essential maternal and postnatal care services. While 87.3% of women attending antenatal care by skilled personnel, there is relatively low coverage of Lady Health Workers (LHWs) at 54.5%, and access to frontline healthcare providers remains limited. Additionally, postnatal care for newborns and mothers stands at 68.5% and 70.1%, respectively, indicating gaps in critical support and counseling on family planning during the postpartum period.[9]

The data on family planning counseling during the last pregnancy leading to a live birth provides valuable insights into the accessibility and utilization of reproductive health services across various demographics in Punjab. There are noticeable variations in family planning counseling rates across different divisions of Punjab.[9] Bahawalpur and Lahore divisions exhibit higher percentages of women counseled for family planning, indicating potentially better access to reproductive health services or stronger emphasis on family planning interventions in these regions.[9] On the other hand, divisions like Sahiwal and Multan show lower rates, suggesting a need for targeted interventions to improve access to family planning counseling in these areas. [9]

Table 8: Access to FP Counseling in Punjab, overall % and by division, and place of delivery

	Percentage of women who, during the last pregnancy that led to a live birth, had been:			Counselling on planning methods before leaving the health facility
	Counseled for family planning	Told about family planning methods	Guided where to get family planning methods	
Punjab	20.3	18.6	17.7	16.0
Urban	17.6	16.3	15.6	14.0
Rural	20.3	18.6	17.7	16.0
Division				
Bahawalpur	28.7	26.6	24.5	22.6
D. G. Khan	13.8	13.3	13.5	11.9
Faisalabad	19.1	17.5	17.0	15.8
Gujranwala	18.0	16.2	16.3	14.1
Lahore	29.4	27.7	25.9	23.6
Multan	13.1	12.2	11.4	10.6
Rawalpindi	23.1	20.9	19.7	17.1
Sahiwal	10.4	9.1	8.5	7.4
Sargodha	18.3	16.2	14.6	13.3
Place of delivery				
Health facility	20.3	18.6	17.7	16.0
Public	20.3	18.7	17.4	15.6
Private	20.3	18.6	17.9	16.2

The data also highlight disparities between urban and rural areas. While the overall percentages of women counseled for family planning are similar in urban and rural settings, rural areas consistently show slightly lower rates.[9] This could reflect challenges in accessing family planning services in rural regions, indicating a need for targeted outreach and mobile health services to bridge this gap. Interestingly, there is no significant difference in the rates of family planning counseling between deliveries at health facilities and those at home.[9]

These data underscore the importance of ensuring that PPFP and PAFP counseling services are readily available and accessible in all settings to reach women regardless of where they deliver. Addressing these barriers necessitates improving access to skilled health personnel, strengthening the capacity of frontline healthcare workers, and integrating family planning into maternal and child health services for comprehensive care in Punjab.

Educational and Ecological Assessment of Family Planning Behaviors

Various psychosocial and contextual elements shape individual behaviors, cascading down from system-level factors such as policies, institutions, and service providers. These factors intersect with community dynamics, household structures, and social and gender norms, influencing the capacity of adolescents, youth, women, and men to access health information, products, and services,

particularly concerning family planning and reproductive health (FP/RH).

To diagnose individual level behaviors a gender lens was applied to first describe the role of men in FP/RH behaviors. Following this the PRECEDE Framework[1] was applied to understand the ecology of poor FP/RH behaviors among women by describing Predisposing, Reinforcing, and Enabling factors driving these behaviors.

Family Planning, Gender, and the Role of Men

Beyond availability of counseling and services, there are several demand-side factors associated with low uptake of family planning. These include but are not limited to gender roles, household decision making, and men's readiness for family planning.

In the South Asian context, the intertwined relationships between social, cultural, and religious factors influence gender roles. The choices men make are made based on these social, economic, religious, political factors and other local traditions. For example, men may bear individual responsibility to generate income during times of inflation and economic uncertainty. At the same time, they must continue to adhere to social norms that expect them to assert their masculinity, negatively impacting their family's health outcomes. Additionally, conventionally accepted norms for men relate to traditional notions of masculinity that define roles for women and men, which lead to less communication between the couple and more violence within the relationship.[17]

The husband's role in making decisions about FP has been highlighted in the recent PDHS 2017-18 survey. Of the individuals surveyed, 87% of currently married women using a FP method, the decision to use contraception was made jointly with their husband; for only 7% of these women the decision was made mainly by themselves, and for 6% the husband mainly made the decision. Whereas currently married women not using a family planning method, 70% made the decision not to use family planning jointly with their husband, 9% decided themselves, and for 16% the decision was mainly made by their husband.[5]

Another reason for higher than desirable fertility is the preference for male children, which is a norm created by patriarchal structures in the province. This leads to social aversion to the concept of family planning which influences male perceptions on use of contraception. Social and family expectations require larger families to support with agricultural needs and continue family lineage.

There is some evidence to suggest a shift in men's attitudes towards FP, but more is required to understand their needs. A study based in Punjab explored couples' decision-making processes to understand their perceptions of family size and contraceptive use.[18] Men felt limiting family size would reduce the stresses and expectations of providing for the family which becomes burdensome with a larger family. Moreover, financial pressures on men are causing men to plan births and so improving spousal communication between the couple. However, problems around lack of FP services available to men and the inability for service providers to manage side effects may cause difficulties in supporting men with their intention to space birth or limit pregnancies.[19]

Predisposing Factors

Predisposing factors encompass individual-level psychosocial elements that influence adolescents,

EVIDENCE ON PREDISPOSING FACTORS FOR FAMILY PLANNING IN PUNJAB

The FCDO-funded IRADA project[20] applied the Integrated Behavior Model (IBM) to understand psychosocial drivers of intention to use and adoption of modern family planning methods among married women of reproductive age (MWRA) in rural areas of Punjab province in Pakistan. The study setting comprised six districts (Faisalabad, Nankana Sahib, Sargodha, Narowal, Gujranwala, and Mandi Bahauddin) located in the Punjab. The results validate an IBM-aligned, five-factor behavior change model with intention as the primary predictor of modern method use. Intention itself was predicted by perceived value and personal agency. Perceived health risk was an inverse predictor of perceived value, and Injunctive norm directly predicted perceived value and personal agency. The IRADA model demonstrated strong theoretical sufficiency and explained 71.5% of the total variance in the adoption of any modern method, 91% of the total variance in the adoption of a LARC method, and 34.9% of the total variance in the adoption of a short-term method.

Youth, women, and men's decision making and adoption of health behaviors. These factors encompass aspects such as individual knowledge, skills, emotions, perceptions, and beliefs regarding the outcomes and social approval of behaviors, as well as beliefs about their prevalence and one's own capabilities amidst a complex web of actual and perceived barriers. These beliefs and perceptions are deeply shaped by individuals' interpretations of power, the sense of self, and collective social and gender norms in their families and communities. These individual factors also serve as focal points for communication and non-communication-based SBC strategies aimed at encouraging the adoption of target behaviors by individuals.

Key predisposing factors relatively common across these behaviors include:

- Lack of individual Knowledge regarding FP/RH promoting behaviors and available services.
- Unfavorable attitudes and beliefs related to potential outcomes of engaging in the intended behaviors.
- Anxiety, fear, and mistrust of available skilled care and fear of stigma associated with FP/RH asso-
- Lack supportive perceptions of social and gender norms related to key target behaviors, i.e., behaviors not being socially approved and uncommon among peers and other influencers in the
- community. This is particularly prominent for adolescents and youth.
- Internalized social and gender norms leading to poor perceptions of control and ability to leverage facilitators for accessing skilled care, e.g., low financial autonomy, low decision-making autonomy, and not being permitted or being hesitant to travel alone.
- Inability to pay for transport and/or services and/or contraceptive methods.

Reinforcing Factors

Reinforcing factors are pivotal in shaping individual predispositions towards FP/RH behaviors. Relationships with spouses, family, friends, community members, schools, and workplaces create support networks that reinforce behavioral decisions. Social and gender norms play a crucial role in determining the dynamics of these support networks, influencing whether spouses, family, friends, and community influencers endorse and encourage health-promoting behaviors.

The factors at this level that hinder the adoption of such behaviors serve as focal points for SBC interventions aimed at altering influencer behaviors shaped by social and gender norms. For the predisposing factors described above, reinforcing factors at the household and community level include:

- Misplaced trust among household and community influencers in traditional methods such as home deliveries, remedies, and other traditional practices.
- Resistance from spouses, parents, and in-laws against adopting health-promoting FP/RH behaviors.
- Insufficient support from household and community influencers for health-promoting behaviors within the home, and inadequate encouragement for timely utilization of skilled services FP/RH.
- Lack of accurate knowledge and fatalism among household decision-makers and community influencers regarding the consequences of non-compliance with key behaviors.
- Widespread health service provider bias driven by harmful social and gender norms and provision of disrespectful FP/RH care.
- Community adherence to unfavorable social and gender norms, alongside perpetuation of societal myths, supernatural beliefs, conservative cultural values, and misinterpretation of religious doctrines, limiting agency and choice for adolescents, youth, women, and men.
- Stigma within the community surrounding several behaviors associated with care seeking for FP/RH, include for men and women's use of modern contraception, particularly for younger women and young couples, and men's meaningful involvement in FP/RH matters beyond paying for care.

Reinforcing factors for these behaviors also exist at the institutional and organizational level and include:

- Unfavorable gender and youth sensitive values and beliefs among decision-makers, implementers, and community stakeholders.
- Insufficient motivation among decision-makers and implementers to prioritize healthcare needs related to FP/RH.
- Inadequate knowledge and information regarding the drivers of unhealthy FP/RH behaviors and the detrimental effects of poor health-seeking behaviors on individual, household, and community health.
- Limited community capacity, comprehension, and ownership of priority health concerns.
- Minimal community involvement and inclusion in decision-making processes related to priority FP/RH issues.

Enabling Factors

Enabling factors encompass facilitating factors concerning the availability, accessibility, affordability, and quality of various services, such as income, education and vocation, social support, and healthcare, tailored to individuals' specific needs. Within the realm of FP/RH, this entails not only aspects related to the availability and accessibility of services but also emphasizes the importance of service providers' clinical and behavioral proficiency. This proficiency ensures the delivery of high quality, gender-sensitive, youth-responsive, person-centered, and respectful counseling and care for priority health-promoting behaviors. Factors to address for creating an enabling environment for FP/RH include:

- Lack of accessible information and services, particularly for youth.
- Poor quality of clinical care services being delivered.
- Lack of appropriate counselling skills of health workers and service providers and lack of integration of value clarification and attitude transformation (VCAT) approaches in multi-faceted provider behavior change interventions which also focus on provider norms and provider agency.

- Lack of provider incentives and updated training programs for professionals and quality improvement mechanisms.
- Lack of evidence-based, community-led awareness programs, and community-led messaging in support of priority health behaviors.
- Lack of programs addressing male and community exclusion from FP/RH and supporting meaningful engagement of men and communities, beyond community-based events and awareness raising.
- Lack of initiatives for supporting youth inclusion in decision making and youth-led initiatives.
- Limited deployment of age-appropriate health education initiatives in educational settings for shaping knowledge and attitudes regarding family planning in adolescents and youth.

Key Behaviors to Change

Table 9 outlines key behaviors to be addressed and target audiences for SBC interventions in the context of FP/RH.

At the **individual level**, unmarried adolescents and youth represent a priority audience with a need to address poor information seeking behaviors for family planning, low service utilization for adolescent and youth sexual and reproductive health needs and supporting empowerment initiatives to prevent early marriages.

Also at the **individual level**, there is a need to improve family planning and related reproductive health behaviors across life stages. among married women of reproductive age (MWRA) and married men. These include lack of birth planning, lack of contraceptive use to prevent adolescent pregnancies, low modern contraceptive use to delay first birth and for birth spacing of non-first births, lack of complete ANC and PNC visits, sub-optimal use of skilled birthing care and facility births, and the associated low uptake of PPFP and PAFP.

At the **household-level** interventions should focus on engaging husbands to address financial support, financial agency, inter-spousal communication, and encouragement towards health-seeking behavior. Additionally, interventions targeting mothers-in-law are essential to address opposition to shared decision-making and family planning, and to enhance support for communication between spouses.

At the **community level**, engagement with religious and community leaders, community organizations, and peer groups is crucial to address issues such as inadequate involvement in key health issues, low endorsement of health behaviors by community influencers, and lack of community ownership of initiatives.

At the **service delivery level**, SBC interventions should target facility and community-based health care providers to address provider bias and improve clinical and behavioral competence in delivering gender-sensitive, youth-sensitive, and person-centered family planning and RH care and services, with a focus on PPFP and PAFP.

Finally, at the **institutional and policy level**, targeting decision-makers and influencers is essential to prioritize stewardship for maternal and reproductive health care services overall, and also to establish a systematic process for collaborating and operationalizing this strategy for advancing multi-channel, targeted SBC initiatives for priority audiences to promote the adoption of healthy family planning and reproductive health behaviors.

Table 9: Summary of key family planning and reproductive health behaviors to change

Level	Audience	Behaviors to change
INDIVIDUAL	Unmarried adolescents and Youth	• Poor information seeking behaviors for family planning • Lack of service utilization for adolescent and youth sexual and reproductive health needs • Early marriages
	Married women of reproductive age (MWRA) and Married Men	• Lack of birth planning • Lack of contraceptive use to prevent adolescent pregnancies • Low modern contraceptive use to delay first birth • Low modern contraceptive use for birth spacing • Lack of complete ANC and PNC visits • Sub-optimal use of skilled birthing care and facility births • Low use of post-pregnancy family planning
HOUSEHOLDS	Husbands	• Lack of favorable disposition towards family planning Lack of financial support • Lack of inter-spousal communication • Mistrust towards spouses • Refusal to accompany spouses to healthcare facilities, • Lack of encouragement for wives towards health-seeking behaviors.
	Mothers-in-law	• Opposition to shared decision-making and family planning. • Lack of support for interspousal communication
COMMUNTIY	Religious leaders, Community leaders, community activities, and peers	• Lack of adequate engagement and involvement in key health issues at the community level • Low levels of endorsement by community influencers for key health behaviors and initiatives • Lack of community ownership of initiatives.
SERVICE DELIVERY	Facility and community-based health care providers	• Provider bias and poor clinical and behavioral competence for delivering gender and youth sensitive, person-centered care and services. • Counsel women on PPFP during ANC, at the time of birth, and during PNC.
INSTITUTIONAL & POLICY	Decision makers and Influencers	• Lack of prioritization of stewardship for SBC to promote adoption of family planning and reproductive health care services

FAMILY PLANNING IN PUNJAB – POLICY & SYSTEMS CONTEXT

The GoPb is committed to achieving universal access to reproductive health and to raising the CPR to 60 percent by 2030.

The **Population Welfare Department (PWD)** is the focal institution manage the provision of family planning services throughout province. It delivers information and services through a field infrastructure of 2100 Family Welfare Centres (FWCs), 129 Family Health Centres (FHCs), mobile/outreach services, with 1300 social mobilizers for male engagement, as well as 4200 male and female motivators.

The **Primary and Secondary Health Department (P&SHD)** has a greater reach through its extensive network of health facilities at different levels including 1,317 dispensaries, 2,503 Basic Health Units (BHUs), 326 Rural Health Centers (RHCs), 132 Tehsil Headquarters Hospitals (THQHs), and 33 District Headquarters Hospitals (DHQHs). Also operating under the Integrated Reproductive, Maternal, Newborn, Child Health and Nutrition Program's (IRMNCH & NP) there is dynamic cadre of over 42,000 Lady Health Workers (LHWs) and 1,757 Lady Health Supervisors (LHSs) with 30% coverage in urban Punjab and 73% coverage in rural areas. In covered areas, LHWs are still the first line of information for healthcare.

However, due to lack of meaningful coordination between PWD and P&SHD, competing priorities, dilution of LHW tasks, and lack of clarity on scope of work for different cadres of health workers pertaining to family planning, integration of family planning in reproductive health services delivered by these channels remains aspirational to date.

The **Punjab Family Planning Program (PFPP)** which utilizes a Program-for Results lending instrument supported by the World Bank was launched in 2023 to address the wide range of barriers described above. The PFPP is aimed at strengthening the PWD program in alignment with the Punjab Health Sector Strategy 2019–28 and improving coordination between PWD and IRMNCH. The investment focuses on three result areas which capture all the Operational Strategies of the PWD and Outcome 1 of the Punjab Health Sector Strategy 2019–28.

These include:

1

Results Area:
Improved availability of family planning services and commodities

2

Results Area:
Increased demand for family planning commodities

3

Results Area:
Improved advocacy and leadership

The theory of change and the results framework matrix of the PFPP provides a strategic roadmap for guiding the development of a robust SBC strategy for driving demand for family planning in the province.

Section 2

Technical Approach

The SBC Strategy presented in subsequent sections draws strength from grounding in evidence through the following:

- An analysis of key behaviors and behavior trends related to FP/RH to identify behaviors to change mapped to specific audiences.
- An analysis of educational and ecological factors that underpin these behaviors, classified as predisposing, reinforcing, and enabling factors.
- Identification of key behaviors to promote mapped to different audience segments and linked across six interlinked levels of influence described by the Social Ecological Model (SEM)21; and
- Theoretical underpinning from established theories of behavior change, which strengthens the SBC approach by conceptualizing theory-driven pathways of change (e.g., what beliefs and perceptions to change for promoting key behaviors related to FP/RH). The framework and technical approach are described below.

An Integrated SBC Strategy Framework

The SBC Strategy described in subsequent section applies a multilevel SBC Framework for identifying key communication and engagement objectives linked to audiences and priority behaviors to change and mapping interventional modalities for different levels of the SEM.

The framework consists of a strategy framework (Figure 4) that consists of three interlinked strategies informed by the change theory-guided behavior change pathways for each level that are presented in the theoretical framework.

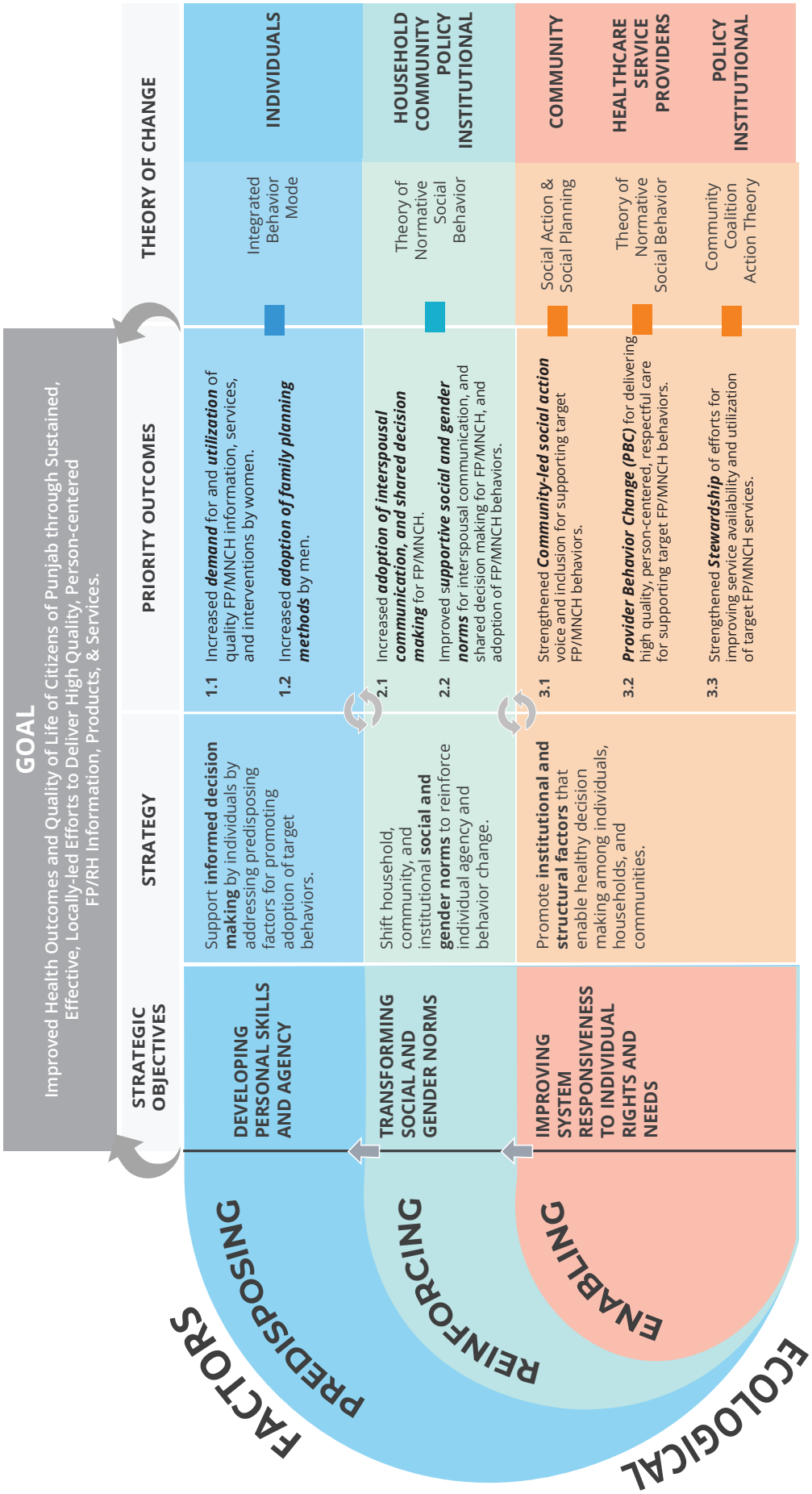
STRATEGY 1 centers on nurturing personal skills and agency to foster informed decision-making, among married women and men of reproductive age. By addressing predisposing factors that impede the adoption of target behaviors, the strategy aims to boost demand for and utilization of high-quality FP/RH information, services, and interventions, the increased adoption of male family planning methods.

This strategy endeavors to assist individuals in developing intentions for health-promoting FP/RH behaviors by refining attitudes, strengthening personal agency, and reshaping perceptions of social and gender norms associated with these behaviors.

To aid individuals in transitioning from intention to action, our programs will prioritize enhancing individual knowledge and skills, mitigating environmental constraints, and emphasizing the importance of health-promoting FP/RH behaviors for individuals and their influencers.

This approach facilitates the meticulous contextualization of behaviors for both women and men for the operational integration of concepts from health behavior theory, ultimately enhancing the uptake of services and products.

Figure 4: SBC Strategy and Technical Framework



STRATEGY 1
SUPPORT INFORMED DECISION MAKING BY INDIVIDUALS BY ADDRESSING PREDISPOSING FACTORS FOR PROMOTING ADOPTION OF TARGET BEHAVIORS.

Strategy Outcomes

1.1. Increased demand for and utilization of quality FP/RH information, services, and interventions by women.
1.2. Increased adoption of family planning methods by men.

STRATEGY 2
SHIFT HOUSEHOLD, COMMUNITY, AND INSTITUTIONAL SOCIAL AND GENDER NORMS TO IMPROVE MALE ENGAGEMENT AND REINFORCE INDIVIDUAL AGENCY AND BEHAVIOR CHANGE.

Strategy Outcomes

2.1. Increased adoption of interspousal communication, and shared decision making for FP/RH
2.2 Improved supportive social and gender norms for interspousal communication, shared decision making for FP/RH, and adoption of FP/RH behaviors.

STRATEGY 3
PROMOTE INSTITUTIONAL AND STRUCTURAL FACTORS THAT ENABLE HEALTHY DECISION MAKING AMONG INDIVIDUALS, HOUSEHOLDS, AND COMMUNITIES.

Strategy Outcomes

3.1. Strengthened Community-led social action, voice, and inclusion for supporting target FP/RH behaviors.
3.2. Provider Behavior Change (PBC) for delivering high quality, person-centered, respectful care for supporting target FP/RH behaviors.
3.3 Strengthened Stewardship of efforts for improving service availability and utilization of target FP/RH services.

STRATEGY 2 endeavors to overhaul social and gender norms across household, community, and institutional spheres to bolster individual agency and facilitate behavior change. This endeavor encompasses fostering enhanced interspousal communication and shared decision-making for FP/RH and advocating for supportive social and gender norms conducive to FP/RH behaviors.

By reshaping norms to endorse individual agency and collaboration within families and communities, the strategy aims to cultivate an environment conducive to healthier behaviors and decision-making concerning FP/RH, with a specific focus on men's roles as users and advocates. Programs targeting the transformation of perceived norms to enhance individual agency and behavior change must consider the broader context and structures that reinforce these norms. To establish an enabling normative environment, the strategy encompasses communication and engagement strategies aimed at fostering normative beliefs that support informed decision-making regarding FP/RH among women and men and their influencers at the household, community, and institutional levels.

STRATEGY 3 focuses on enhancing the responsiveness of systems to individual rights and needs, thereby promoting institutional and structural factors that facilitate healthy decision-making among individuals, households, and communities. This involves strengthening community-led social action and inclusion, promoting behavior change among healthcare providers to deliver high-quality, person-centered care, and enhancing stewardship efforts to improve the availability and utilization of FP/RH services.

By improving system responsiveness to individual rights and needs, the strategy aims to streamline access to and utilization of FP/RH services while ensuring the delivery of these services with dignity and respect. Interventions employ a participatory, empowerment approach to support SBC at all levels of the social-ecological context. SBC strategies will mobilize key household and community influencers to publicly advocate for positive social and cultural norms that support everyone's right to access FP/RH services. Strategic components emphasizing greater community ownership and advocating for favorable local institutional policies, as well as political and social accountability, will further bolster and reinforce these normative outcomes.

Theoretical Framework: Conceptualizing a Holistic Theory of Change

The Framework is a multi-level application of the SEM, which integrates a focus on social norm shifting for gender transformation to support sustained demand creation and mobilization for health promoting services and products. It presents a set of theory-driven communication and engagement objectives at different levels of influence.

- At the individual level informed by the Integrated Behavior Model (IBM).[20,22,23,24]
- For shifting social and gender norms at all levels objectives are informed by the Theory of Normative Social Behavior (TNSB)[25,26,27]
- At the level of the community, engagement objectives are informed by the Social Planning and Social Action Model (SAPM)[28,29,30] of community building, a
- Finally, the change mechanism and objectives for strengthening stewardship of SBC in the province are informed by the and the Community Coalition Action Theory (CCAT).[31,32]

This integrated framework of individual, interpersonal, and group-level theories of SBC at different levels of the SEM was applied to identify psychosocial constructs theorized to drive behavior change. These factors have been operationalized in this strategy as communication and engagement objectives for identified audiences.

Theory of Change for Individual Behaviors (Strategy 1.1, 1.2)

Communication, engagement, and behavior change objectives at the individual level were defined using the Integrated Behavior Model (IBM) to explain how the strategy will build intention and facilitate the transition from intention to behavior.

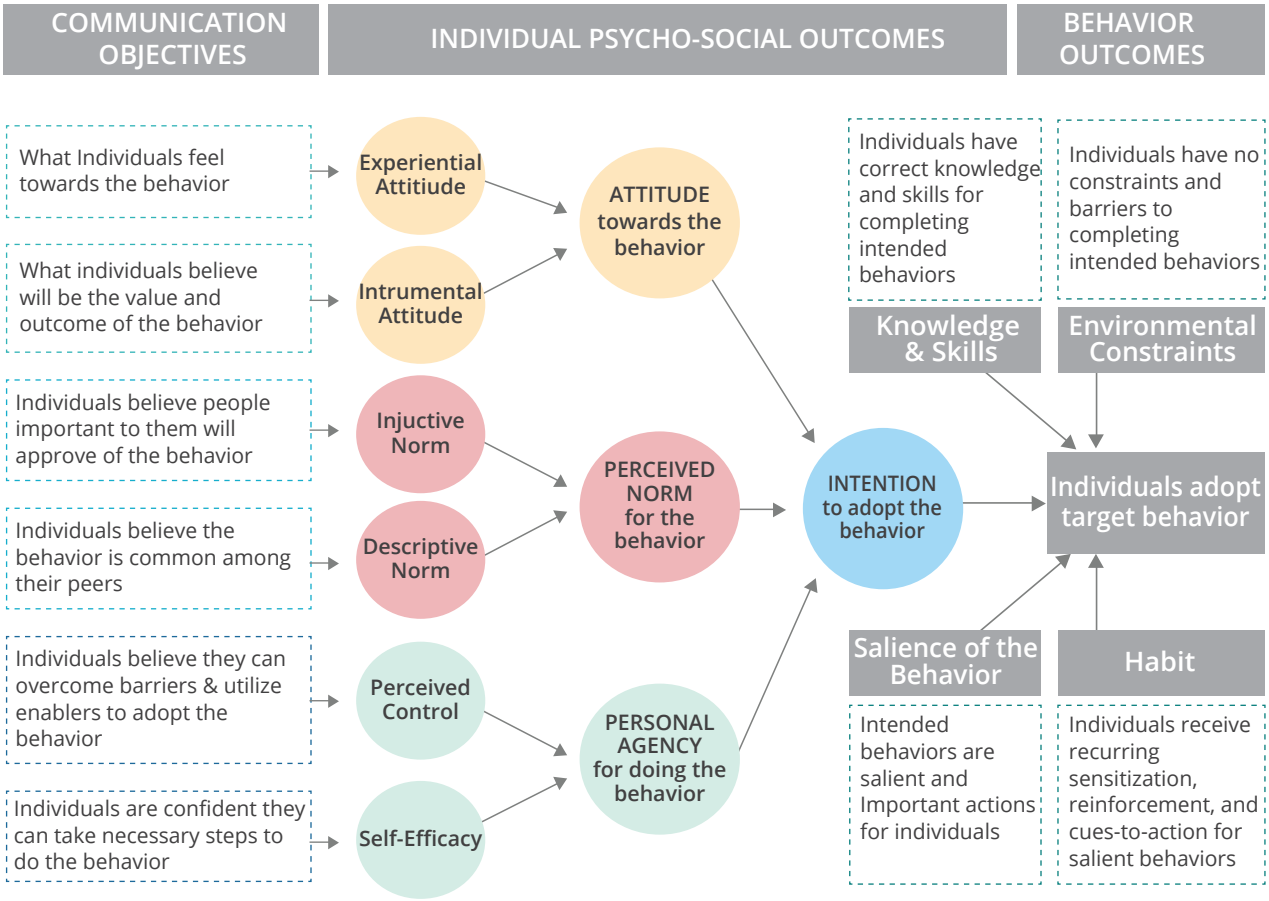
Change Hypothesis

IBM posits that the adoption of target behaviors is primarily determined by the intention to adopt that behavior. Intention, in the framework, is driven by an individual's affective, cognitive, normative, control, and efficacy beliefs and perceptions regarding target FP/RH, and management behaviors.

These sets of beliefs are identified in IBM as attitude, perceived norm, and personal agency. These psychosocial antecedents represent potentially measurable foci for effective communication, and engagement and are theorized to predict individuals' intention to adopt target behaviors.

The change hypothesis (Figure 5) postulates that ***if SBC communication and engagement activities can achieve the indicated communication and engagement objectives, individuals will experience a favorable shift in perceptions driving intention to adopt target FP/RH, behaviors, and that individuals will transition from intention to adoption of target behaviors if they have the right knowledge and skills, do not experience significant environmental constraints, and if target behaviors are a salient issue, reinforced through cues-to-action to promote habit formation***.

Figure 5: Theory of Change: Individual Behavior Change



Key Concepts Driving Individual Behavior Change

Key concepts described in the change hypothesis are defined by IBM and have been applied to describe communication and engagement objectives for the strategy. These objectives provide the framework for developing targeted and tailored key messages and informing SBC content. Individual-level communication objectives are described in Table 10.

Table 10: Application of the IBM to Describe Individual Level Communication and Engagement Objectives

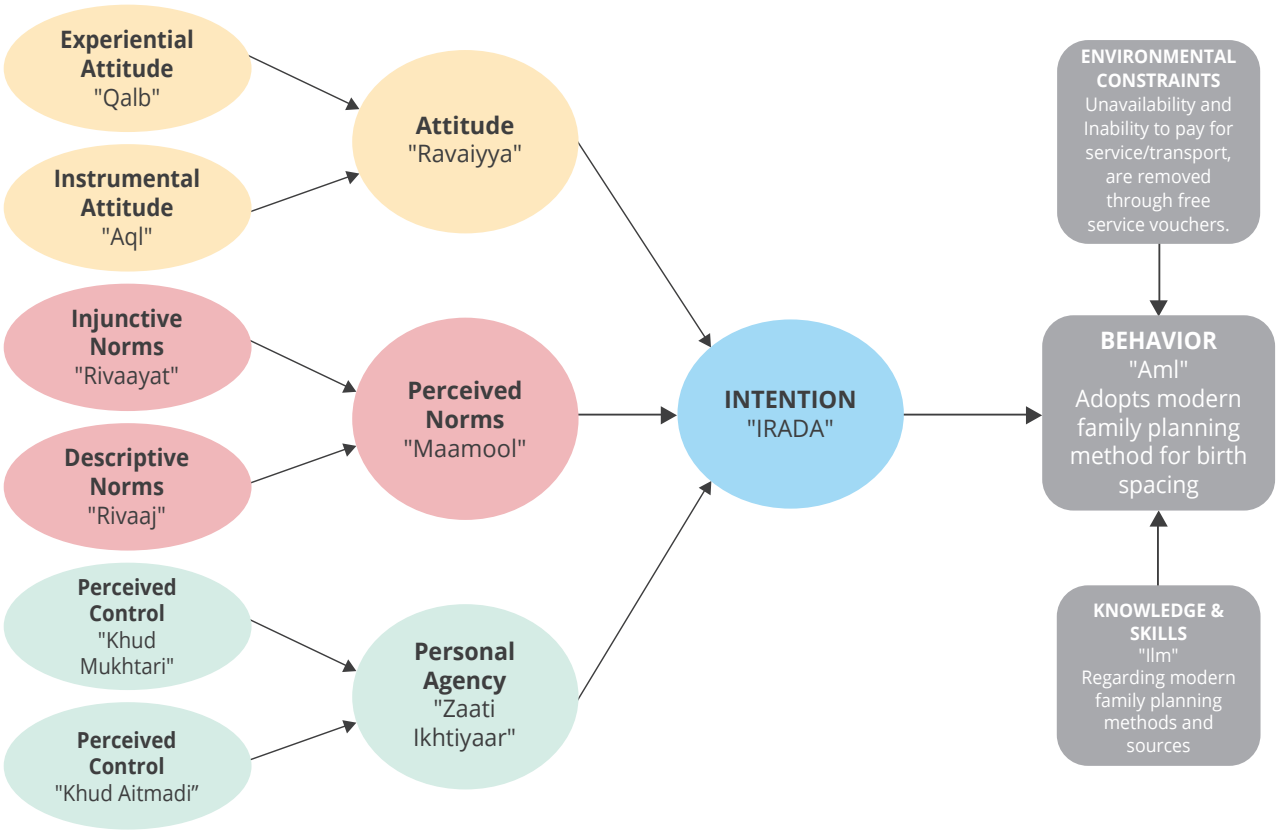
S/No.	Concept	Definition	Communication Objective
1	**Intention**	Perceived likelihood of adopting target behavior.	Individuals engaged through effective SBC messages to develop and voice intention to adopt target behaviors for FP/RH.
1.1	**Attitude**	Overall affective response and cognitive evaluation of the outcomes of engaging in target behavior.	**Experiential attitude:** Individuals have favorable affective response to adoption of target behaviors for FP/RH **Instrumental attitude:** Individuals believe that adoption of target behaviors for FP/RH, is responsible, and wise behavior, that it is safe and effective, and will yield beneficial outcomes for them and the family.
1.2	**Perceived Norms**	Perceived expectations from peers, key influencers & observed behavior of peers and influencers related to target behavior.	**Injunctive norm:** Individuals believe that people important to them will approve of them adopting target behaviors for FP/RH, **Descriptive norm:** Individuals observe their peers and influencers adopting target behaviors for FP/RH
1.3	**Personal Agency**	Overall perception of ability to overcome barriers and confidence in ability to complete the target behavior.	**Perceived Control:** Women believe that they can overcome potential barriers and that there are enablers which they can utilize to adopt and sustain target behaviors for FP/RH **Self-efficacy:** Individuals are confident that they can take necessary steps to adopt and sustain target behaviors for FP/RH
2	**Knowledge & Skills**	Overall knowledge and skills for completing target behavior.	Individuals have right knowledge, and skills for adoption of target behaviors for FP/RH
3	**Environmental Constraints**	Constraints experienced by individuals preventing the behavior from taking place.	Individuals do not perceive any major barriers in their environment for adopting and sustaining target behaviors for FP/RH

Establishing Cultural Congruence for Punjab

There exist concerns among practitioners that western-oriented theories of change lack applicability in more eastern contexts. However, health psychologists support the notion that key concepts described in leading theories of behavior change exist in human nature and while their accurate measurement is a function of language and culture, these concepts can be found in all human populations. The technical approach driving the SBC strategy gains credence and cultural congruence by mapping of key communication objectives described in the change pathways above against culturally congruent concepts described by Imam Abu Al Ghazali in the 11th century C.E.

Al Ghazali in his treatise describing human nature and human behavior, describes the first ever behavior framework which identifies Irada (intention) as the primary predictor of action by individuals. Al Ghazali postulates that Irada, or intention is driven by Ilm (knowledge), Aql (cognitive understanding), and Qalb (feelings towards the behavior), along with whether an individual has Ikhtiyar (volitional control) over the behavior. These concepts are embodied in IBM predicting behavior change among individuals. Key concepts in the core theory at the individual level, IBM, have also previously been translated into cultural congruent concepts to predict family planning use in Punjab, and these have been validated conceptually and empirically through measurement (Figure 6).[20]

Figure 6: The IBM translated to culturally congruent and locally understood concepts – The IRADA Model[20]



Building communication and engagement objectives around psychosocial concepts that translate into locally understood concepts allows the strategy to maintain cultural congruence and sure that field staff can conceptualize these communication objectives in locally relevant terms.

Theory of Change for Shifting Social, Gender, and Professional Norms (Strategy 2.1, 2.2, 3.2)

The strategy conceptualizes communication objectives related to norm shifting for supporting behaviors in different interpersonal settings for audiences at all other levels: household (spouses, partners, caregivers, mothers- and fathers-in-law, other family influencers), service delivery (providers), institutional, and policy. These were identified by applying the Theory of Normative Social Behavior (TNSB) to theorize a pathway of change that leverages the power of perceived norms

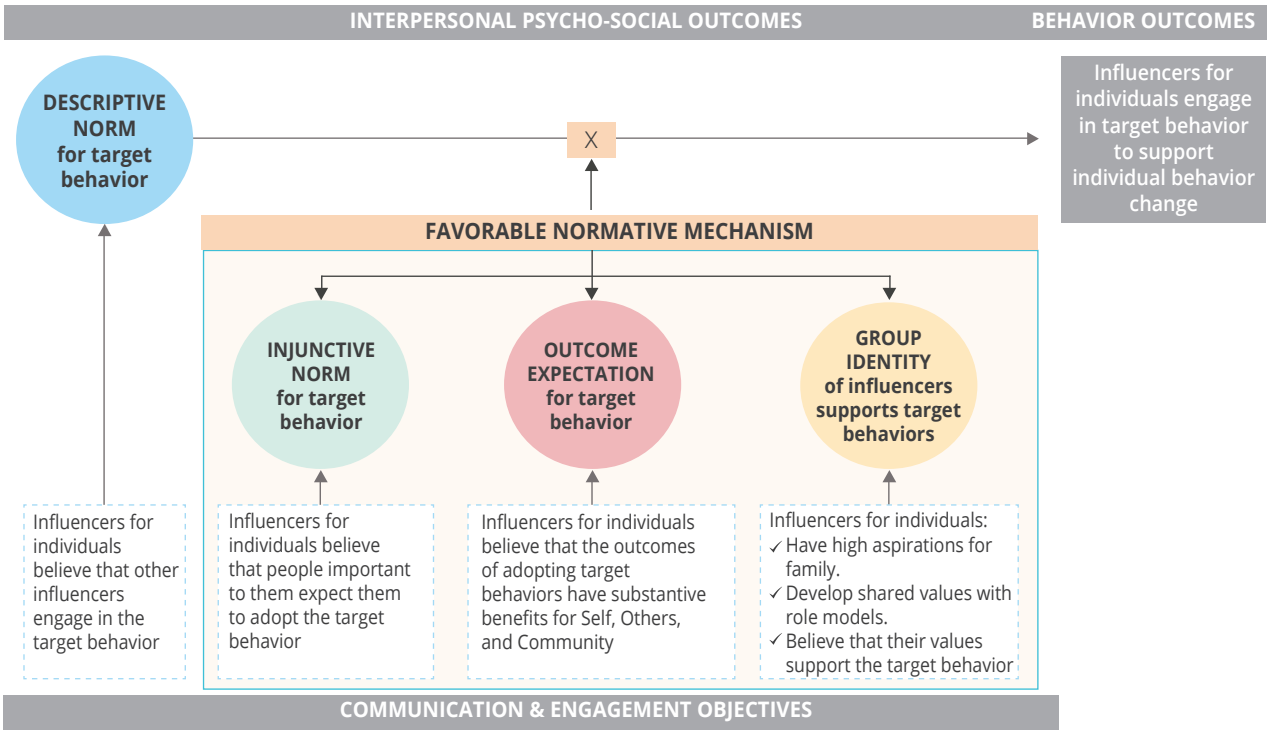
to promote change in supportive behaviors among key influencers for individuals.

Change Hypothesis

The theory of change for creating favorable social and gender norms for the adoption of target health behaviors focuses on intergenerational and interspousal communication for supporting these behaviors and endorsement by household and community influencers for interspousal communication and adoption of target behaviors.

The change hypothesis states that ***Descriptive norm (i.e. perceptions about how common key behaviors are among peers) related to interspousal/intergenerational communication and dialogue, timely adoption of health promoting FP/RH behaviors, will encourage husbands and other household influencers to adopt these behaviors themselves if the interventional strategies create Favorable Normative Mechanism by improving Injunctive Norm (i.e. perceived likelihood of social approval/social expectation of key behaviors), Outcome Expectations (i.e. perceived benefits and value of adopting key behaviors), and promoting aspirational values through highlighting role models to promote Group Identity.*** The change pathway is presented in Figure 7.

Figure 7: Theory of Change: Shifting Social & Gender Norms



Key Concepts Driving Change in Behaviors through shifts in Perceived Social and Gender Norms

Key concepts described in the change hypothesis are defined by the TNSB and have been applied to describe interpersonal communication and engagement objectives for the strategy for shifting social and gender norms, shown in Table 11. These objectives provide the framework for developing targeted and tailored key messages and informing SBC content for norm shifting.

Table 11: Application of the TNSB for Identifying Interpersonal Communication and Engagement Objectives for Shifting Social and Gender Norms

S/No.	Concept	Definition	Psycho-Social Communication Objective
1	**Descriptive Norm**	Observed practices of peers and community influencers related to target behavior	Household & Community influencers observe/ perceive that other households and community influencers are supporting inter-spousal/ inter-generational communication for adoption of target behaviors for FP/RH
2	**Favorable Normative Mechanism**		
2.1	**Injunctive Norm**	Perceived expectation of social approval of target behaviors from key influencers	Household & Community influencers believe that supporting inter-spousal/inter-generational communication for adoption of target behaviors for FP/RH is expected of them.
2.2	**Outcome Expectation**	Cognitive outcome evaluations and expectations of benefits of adopting target behaviors	Household & Community influencers believe that supporting and encouraging inter-spousal/inter-generational communication for adoption of target behaviors for FP/RH will have substantive benefits.
2.3	**Group Identity**	Perceptions of shared values with role models who engage in the target behavior and adoption of aspirational values demonstrated by role models.	Household & Community Influencers identify as supportive and socially responsible elders/heads of households and develop shared values with role models who support inter-spousal/inter-generational communication for adoption of target behaviors for FP/RH, mental health, and cancer prevention.

Theory of Change for Community Empowerment (Strategy 3.1)

Community empowerment for FP/RH requires integrating a meaningful empowerment education process in the strategy. The strategy conceptualizes community empowerment through the application of concepts from the Social Action and Social Planning Model and principles of participatory methodology, to identify communication and engagement objectives for community empowerment capable of supporting the transformation process.

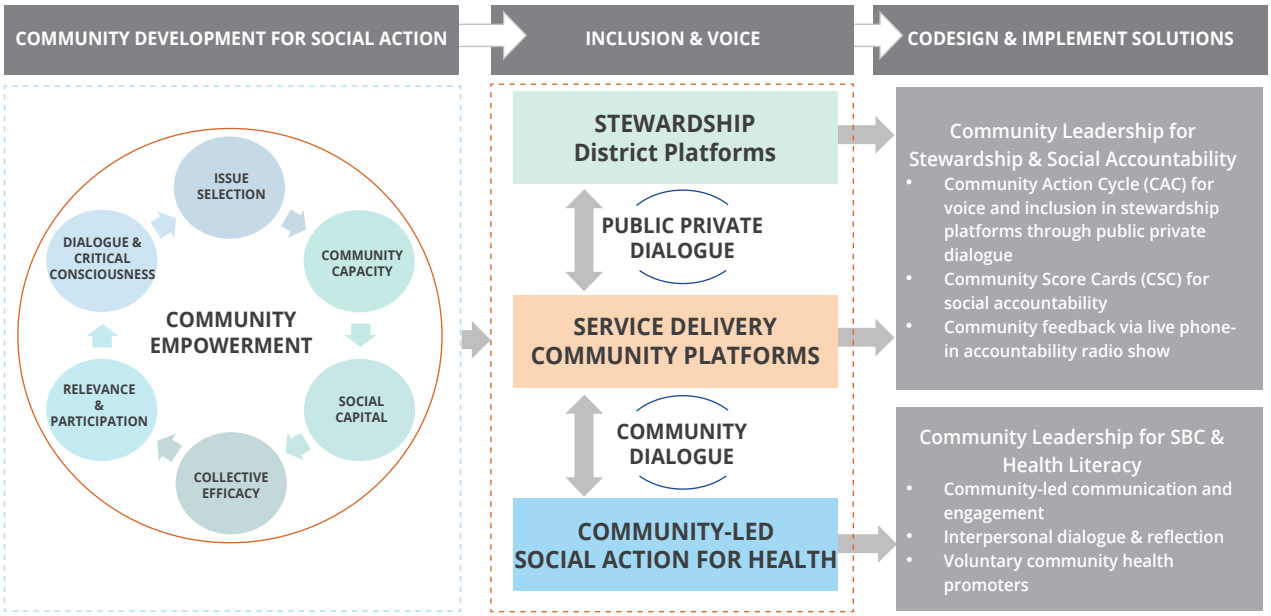
Change Hypothesis

The change hypothesis infers that supporting community building, dialogue, critical reflection, and community inclusion aimed at empowerment can address affective, normative and efficacy beliefs at the individual household, and community levels, and support the transition from intention to

action by individuals and their influencers. The framework draws strength from the following theory-supported assumptions guiding the mechanism of change:

- For community engagement to be meaningful, it should be relevant to the people and should be predicated on the community's ownership and participation.
- The process for engagement should be aimed at increasing critical consciousness related to a community's need for FP/RH services.
- If communities are supported through capacity building to improve their knowledge and skills on FP/RH, they will, in turn, be able to identify locally relevant barriers and health or social issues that most affect them in these domains.The process for engagement should be aimed at increasing critical consciousness related to a community's need for FP/RH services.
- With increased social capital and capacity, community representatives will lead community-efforts to shift related norms, if resources and support are available.

Figure 8: Theory of Change: Community empowerment and social action



Thus, the theoretical concepts applied at the community level will include Participation and Relevance, Critical consciousness and Issue Selection, and Social Capital and Collective Efficacy leading to improved Community Capacity and Empowerment. Figure 8 summarizes the key concepts in the Community Empowerment Framework and their anticipated outcomes.

Key Concepts Driving Community Empowerment

Key concepts described in the community-level change hypothesis are defined by the SASP and have been applied to describe community mobilization, development, and engagement objectives for supporting community-led social action for FP/RH SBC. These objectives (Table 12) provide the framework for guiding the community development interventions for supporting social action cycle for advancing an enabling environment for FP/RH in communities across the Punjab.

Table 12: Application of the Social Action and Social Planning Model for Identifying Community Engagement Objectives for Empowerment

S/No.	Concept	Definition	Communication & Engagement Objective
1	**Empowerment**	Social action process for people to gain mastery over their lives and the lives of their communities.	Community organization, capacity building, and increased critical consciousness for greater power to create desired changes in the issues related to people's health and well-being, particularly around interspousal and intergenerational communication for and supporting the adoption of skilled FP/RH services by individuals.
2	**Community Capacity**	Community characteristics affecting its ability to identify, mobilize, and address problems.	Community members can lead activities aimed at identifying and solving their problems related to interspousal and intergenerational communication for adoption of FP/RH services and become better able to address future problems collaboratively.
3	**Collective Efficacy**	Community level of perceptions that they can successfully work together to address and solve priority problems.	Community stakeholders proactively own and lead social action for SBC related to interspousal and intergenerational communication for and promoting adoption of FP/RH services.
4	**Social Capital**	Relationships between community members including trust, reciprocity, and civic engagement.	Community stakeholders collectively improve leadership, social networks, and quality of community life through participatory reflection and dialogue aimed at movement building to address barriers to interspousal and intergenerational communication for and adoption of FP/RH services.
5	**Issue Selection**	Identifying winnable and specific targets of change that unify and build Community strength.	Community stakeholders identify issues through participation, reflection, and analysis of lived experiences, aspirations and discrepancies between lifestyles and aspirations to identify issues of importance and relevance to interspousal and intergenerational communication for, and adoption of FP/RHservices.
6	**Critical Consciousness**	A consciousness based on reflection and action in making change.	Community stakeholders engage in dialogue that enables them to link root causes and promote critical thought regarding the importance of interspousal and intergenerational communication for and adoption of FP/RH services.

Theory of Change for Improved Stewardship of SBC for FP/RH (Strategy 3.3)

The strategy also proposes simultaneous capacity building and health-system strengthening approaches at institutional and policy levels for supporting and sustaining SBC at more proximal levels. The implementation approach comprises a sequential cycle of activities designed to facilitate PWD in stewarding[36] a systematic mechanism for collaboration between the public and private sector to ensure a comprehensive roll out of the SBC strategy for enhancing family planning in Punjab. The stewardship action cycle, which applies the Community Coalition Action Theory (CCAT), comprises of five implementation phases which sequentially feed into each other, aimed at achieving the following outcomes:

1. Improved collaboration between & capacity of stakeholders for undertaking theory-driven, locally led SBC for FP/MNCH.
2. Improved reach, quality, targeting, and consistency of SBC messages for FP/MNCH.
3. Increased availability of FP/MNCH information, and services.

STEWARDSHIP

Stewardship is defined as the ethical use of common resources in pursuit of financially efficient outcomes, underpinned by the values of trust, ethical behavior, and sound decision-making. Drawing on the concept of health system stewardship, this strategy operationalizes this definition to encompass six critical governance and leadership behaviors:

1. Defining the vision and strategies for better health,
2. Exerting influence across all sectors,
3. Ensuring good governance,
4. Ensuring alignment of capacities and system design with system goals,
5. Leveraging and utilizing policy instruments to steer performance, and
6. Supporting evidence utilization through data-driven dialogue and consensus.

These are presented in Figure below and described in more details under strategy 3.3.

Phase 1. Strengthen Stewardship for SBC for FP/RH: PWD will enhance stewardship, foster partnerships, and create an activity roadmap. With technical assistance, PWD will establish a robust Family Planning SBC Working Group through a consultative process.

Phase 2. Establish Funding and Financing Mechanisms for SBC FP/RH: This phase focuses on ensuring sustained financing by diversifying funding sources and promoting synergy among stakeholders. PWD will develop a costed implementation plan and conduct a fiscal space analysis to create a sustainable funding ecosystem.

Phase 3. Co-create Activity Designs, FP/RH Campaign, and Validation of IEC Materials: PWD will address gaps in SBC materials by co-creating activities with stakeholders. This involves developing a detailed activity plan, aligning efforts with objectives, and ensuring clear roles during the development and validation of FP SBC resources.

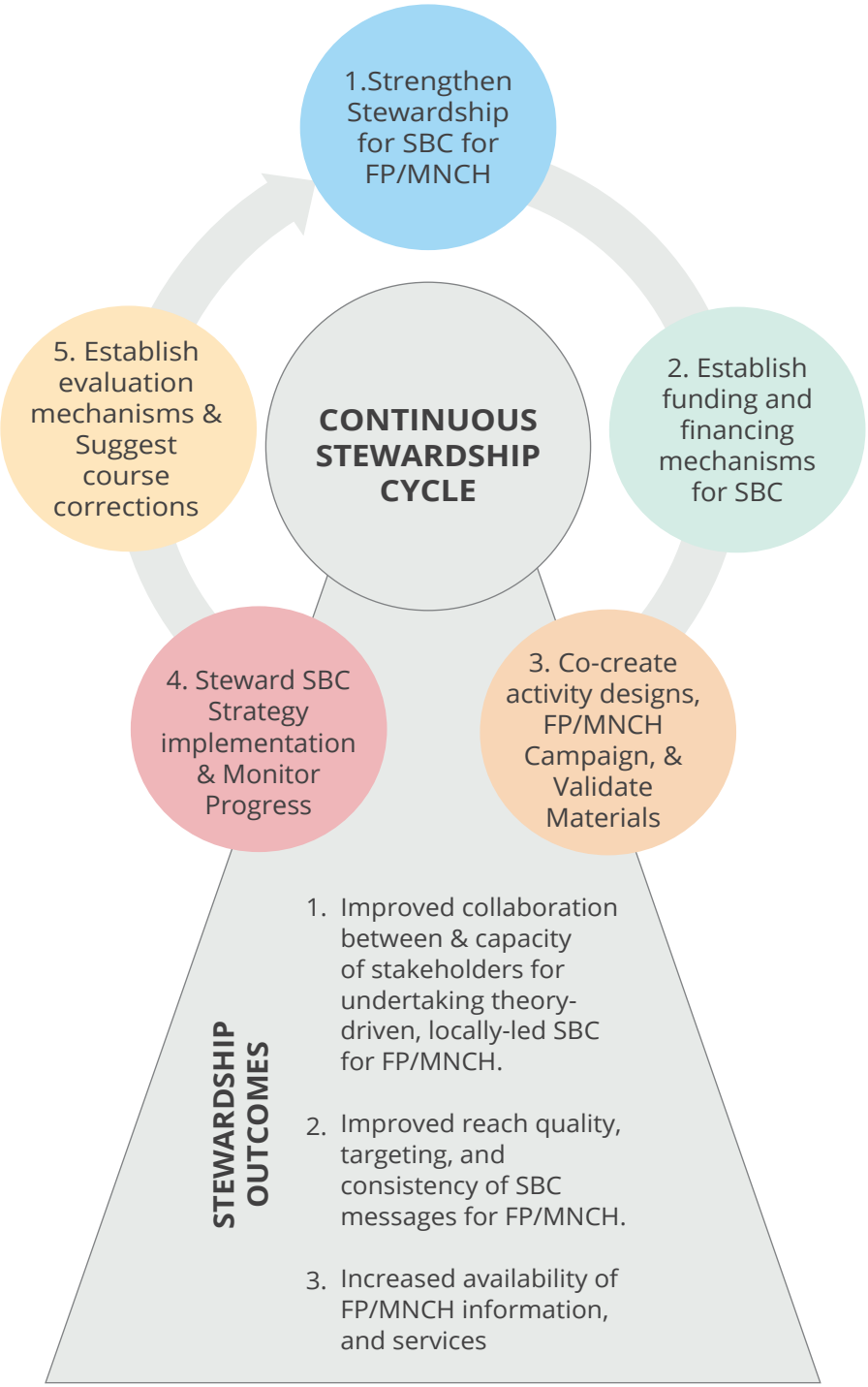
Phase 4. Steward SBC Strategy Implementation & Monitor Progress: PWD will implement and incrementally roll out activities, facilitating stakeholder dialogue and conducting regular reviews.

Quarterly progress meetings will ensure alignment and adaptation.

Phase 5. Establish Evaluation Mechanisms & Suggest Course Corrections: Emphasizing evidence-based decision-making, PWD will guide the SBC Working Group in developing robust evaluation mechanisms. This will refine strategies, promote male involvement in family planning, and enhance reproductive practices in Punjab.

Please see Strategy 3.3 for additional details

Figure 9: Theory of Change for improving Stewardship of SBC for FP/RH



Section 3

SBC Strategy for promoting FP/RH Behaviors in Punjab

Goal

Improved health outcomes and quality of life of citizens of Punjab through sustained, effective, locally led efforts to deliver high quality, person-centered FP/RH information, products, and services.

Key Strategies and Outcomes

Strategy 1: Support informed decision making by individuals by addressing predisposing factors for promoting adoption of target behaviors.

Strategy Outcomes:

1.1. Increased demand for and utilization of quality FP/RH information, services, and interventions by women.
1.2. Increased adoption of family planning methods by men.

Strategy 2: Shift household, community, and institutional social and gender norms to improve male engagement and reinforce individual agency and behavior change.

Strategy Outcomes:

2.1. Increased adoption of interspousal communication, and shared decision making for FP/RH
2.2. Improved supportive social and gender norms for interspousal communication and shared decision making for FP/RH, and adoption of FP/RH behaviors.

Strategy 3: Promote institutional and structural factors that enable healthy decision making among individuals, households, and communities.

Strategy Outcomes:

3.1. Strengthened Community-led social action, voice, & inclusion for supporting target FP/RH behaviors.
3.2. Provider Behavior Change (PBC) for delivering high quality, person-centered, respectful care for supporting target FP/RH behaviors.
3.3. Strengthened Stewardship of efforts for improving service availability and utilization of target FP/RH services.

A preliminary Action Plan with key outputs, and estimated costing for 42 districts of Punjab is presented in Annex 2, along with estimated costing by strategy in Annex 3, and by channel and by medium and channel in Annex 4.

Strategy 1:
Support informed decision making by individuals by addressing predisposing factors for promoting adoption of FP/RH behaviors.

Strategy 1.1: Increased adoption of FP/RH behaviors by women

Audience and Target Behaviors

PRIMARY AUDIENCE	FEMALE YOUTH & WOMEN OF REPRODUCTIVE AGE (15 – 49 YEARS)

AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
UNMARRIED YOUTH (15-29 YEARS)	• Seek age and life stage appropriate information for family planning • Utilize age and life stage appropriate sexual and reproductive health services
NEWLY MARRIED WOMEN	• Adopt modern family planning methods from local health facility, for delaying pregnancy / preventing unplanned pregnancy
MARRIED PREGNANT WOMEN	• Utilize skilled, integrated FP/RH care to complete Key FP/RH Behaviors: 1. 4 Antenatal care (ANC) visits 2. Facility-based birth 3. Timely Postnatal Care (PNC) visit 4. Adopt post-partum family planning method
MARRIED WOMEN WITH CHILDREN	• Adopt modern family planning method from local health facility, for delaying pregnancy / preventing unplanned pregnancy

Communication & Engagement Objectives

I. **Build Intention:** Young women and MWRA develop expectations and intention to adopt skilled, integrated FP/RH care for completing target behaviors.

a. **Improved Attitude:**
   i. Young women and MWRA feel comfortable about utilizing skilled, integrated FP/RH care for completing target behavior.
   ii. Young women and MWRAs believe utilizing skilled, integrated FP/RH care for completing target behavior will lead to better health outcome for self and family.
   iii. Young women and MWRA believe that modern family planning methods are safe and effective for birth spacing.

iv. Young women and MWRA believe that not completing target behavior can lead to significant harm to self and child and incur high healthcare expenses to manage.

b. **Improved Perceived Norm:**
   i. Young women and MWRA believe that her peers and other women in their community are also utilizing skilled, integrated FP/RH care for completing target behavior.
   ii. Young women and MWRA believe that her husband will support her in utilizing skilled, integrated FP/RH care for completing target behavior.

c. **Improved Personal Agency:**
   i. Young women and MWRA do not perceive any major environmental barriers to utilizing skilled, integrated FP/RH care for completing target behavior.
   ii. Young women and MWRA are confident in being able to access transport for reaching local health facility to complete target behavior.

II. **Promote Adoption & maintenance of target behaviors by intending MWRA**

a. Improved Knowledge and Skills: Young women and MWRA have correct knowledge and skills for accessing FP/RH information, products, and services for completing target behavior.
b. No Environmental Constraints: Young women and MWRA can access transport, travel to health facility, pay for services, and negotiate respectful, gender sensitive care from providers/facilities.
c. Cues-to-action: Young women and MWRA understand and apply learnings from Information, Education, and Communication (IEC) materials and want to redeem vouchers and referrals.

Interventional Approach and Activities

1. Strategies for Building Intention among individuals

1.1. COMMUNITY-BASED HEALTH EDUCATION

Family Welfare Workers (FWWs), Family Welfare Assistance (FWAs), Female Motivators, Lady Health Workers (LHWs) and private sector Community Health Workers (CHWs) in LHW uncovered areas, and Community Volunteers will be the primary channels for engaging MWRA on key behavior change themes. The approach to engagement will build on existing established modalities of community-based engagement and include:

1.1.1. Household visits: Tailored interpersonal communication (IPC) using participatory reflection and analysis (PRA) tools including simple tools such as reflexivity using pictures of segment archetypes, Timeline and Daily Routine to trigger thinking around self-care and time management, provision of correct information at key trigger points during discussions, and providing cues-to-action, referrals. Government approved behavior change communication toolkit "Sehat Ki Dastak" will be

used. Health educators will identify and connect key audience segments to group-based community activities.

1.1.2. Community meetings: Government approved behavior change communication toolkit "Sehat Ki Dastak" will be used. Targeted messaging through small group neighborhood meetings using PRA tools such as social mapping, discussions with and information sharing by peer role models, and opinion leaders. Following a similar approach, navigating through tools used in inter-personal settings will help to establish common construal of meaning and develop descriptive norms for target behaviors, e.g., low prevalence, high impact target behaviors such as PPFP and PAFP.

1.1.3. Women's Community Seminars: Through collaborative support, stakeholders will organize Women's Community Seminars aimed at fostering discussions on reproductive health and family planning among women in target communities. These seminars, facilitated by healthcare professionals and community leaders, will provide a platform for women to access accurate information on reproductive rights, contraceptive options, and healthcare services. Through interactive sessions, participants will dispel myths, address cultural barriers, and share experiences, fostering solidarity within communities. PWD stewardship and development partner support will enable the dissemination of knowledge and empowerment, promoting informed decision-making and proactive healthcare-seeking behaviors among women. Furthermore, by endorsing modern family planning methods and child spacing through these seminars, the approach will contribute to establishing descriptive norms and strengthening favorable injunctive norms, empowering individuals and couples to make informed reproductive choices.

SHIFTING PERCEIVED NORM FOR POSTPARTUM FAMILY PLANNING (PPFP) THROUGH COMMUNITY CHAMPIONS AND AMBASSADORS

Given the low prevalence of PPFP and PAFP, creating and reinforcing injunctive and descriptive norm for adoption of modern PPFP will be a foundational focus of community-based engagement in group settings.

Community-based health workers will collaborate with local community volunteers, community champions, and ambassadors who support and practice PPFP, positioned as role models and change agents during community engagement events.

This will involve:

- Deployment of 1,250 Community Volunteers. This will also include male community volunteers (please see strategy 1.2)
- Deployment of networks of **Community Champions** and **BISP Mother Ambassadors** supported by the **Punjab Population Innovation Fund (PPIF)**.
- Articulating clearly defined roles and responsibilities which complement and strengthen health worker-led participatory engagement in group and household settings.
- Delivering orientations, trainings, and capacity development to strengthen and facilitate implementation.

1.1.4. Community Theatre: Community theatre is a form of participatory communication that brings about social change. It is performed by the community for the community. It comes from the premise that, 'development can only be meaningful and sustainable when it is people generated, involving people's real needs and their participation in the process of achieving them[37]. PWD will collaborate with development partners to develop and advance the role of community theater in supporting dissemination of key messages on FP/RH. Following collaborative action planning with development partners, PWD will facilitate and steward women-led community theatre in urban and rural areas across Punjab. These live productions will be led by women for women only audiences and attempt to tackle prevalent obstacles and inspire the uptake of prioritized behaviors.

Key Activities

i. Validation of key messages for girls and women: Guided by the theory of change and evidence-based communication and engagement objectives, PWD will steward the development, testing, and validation of a comprehensive set of key messages for segmented audiences. This will be in collaboration with development partners in the SBC Working Group and will ensure consistency of messaging across channels and partners. These validated messages for different themes will inform the IEC approach and content created for dissemination through a wide range of channels, that will be tailored for different audience segments during operationalization of the strategy.

ii. Development of tailored IEC materials and job aids: PWD will collaborate with FP partners to support the development of client-facing IEC materials (e.g., flyers, leaflets, checklists, etc.) for use in both household and community-group settings. PWD will also steward the development of updated job aids for health educators (e.g., participatory engagement tools, field support manuals with health educator scripts, counseling flipbooks, visiting cards, etc.) to incorporate validated key messages for key themes and participatory approaches in existing cadres of community-based health educators, ensuring ease of integration into existing structures.

iii. Training and capacity development of community-based health educators: PWD will steward a collaboration between P&SHD, and development partners to undertake training and capacity development of FWAs, LHWs, and CHWs in uncovered areas, to develop capacity and equip with IEC materials and job-aids for delivering health promoting information, products, services, and referrals for FP/RH services. The activity will focus on developing a pool of master trainers for step-down cascade training for relevant cadres across priority districts.

iv. Strengthen supportive supervision and synergy across cadres: PWD will collaborate with development partners to conduct a thorough review of the current systems in place for the supportive supervision of key cadres of community-based health educators and identify priority areas of support. These may include deploying supervisors and providing training to existing supervisors on updated IEC materials and job aids, as well as addressing any gaps in the current supervisory mechanisms. Mechanisms will also be identified to support improved synergies across the different cadres, including through standardization of messages and IEC materials.
Collaboration with DoH and development partners will be integral to this process.

POSTPARTUM FAMILY PLANNING (PPFP) A PRIORITY THEME

During the first year of the strategy implementation and as part of the message development phase described under activities, priority attention will be paid to developing a comprehensive set of key messages and IEC materials for PPFP and PAFP from existing resources and delivered through a PPFP focused multi-channel targeted campaign.

1.2. COMMUNITY SIGNPOSTING

PWD, with support from development partners, will adapt PSAs and content described above to develop community signposting in key community traffic areas and common hotspots where key segments of individuals are known to gather. Signposting will focus on highlighting the dangers of poor FP/RH behaviors, endorsement of key messages by government and popular opinion leaders, building salience of key behaviors among individuals, and providing information on where to access counseling and services for FP/RH.

Key Activities

i. Provincial Signposting Approach: PWD will steward the development of community signposting strategy in collaboration with other departments (e.g., P&SH, WDD, etc.) and development partners, identifying key modalities, e.g., community billboards, and banners, branding of retail stores with key messages, and vehicle branding for privately owned vehicles such as rickshaws and QingQis, as well as signposting on public transport. Efforts will be made to

ii. Testing and validation of content with key informants: Content for community signposting will be tested and validated with key informants, including community leaders, healthcare providers, and representatives from relevant government agencies. Feedback will be incorporated to ensure the effectiveness and cultural appropriateness of the messages. Support will be sought from development partners to provide technical assistance.

iii. Community deployment in collaboration with partners and government entities: PWD will work closely with partners and stakeholders to deploy community signposting initiatives. This may involve coordinating with local authorities for permits and approvals, as well as engaging community members in the installation and maintenance of signage. Partnerships with local businesses, transportation providers, and community organizations will be leveraged to maximize the reach and impact of the signposting efforts. PWD with support from development partners will also provide training and support to community members involved in the deployment process to ensure the sustainability of the initiative.

1.3. MASS MEDIA

SBC through local cable television and print media will leverage established media engagement strategies adapted for Punjab. Key interventional approaches will include:

1.3.1. Television Drama Serial on FP/RH: PWD, in collaboration with Punjab Population Innovation Fund (PPIF) will support the development and airing of a high-profile drama serial on major television channels focusing on the theme of FP/RH. The television serial will aim to develop salience of the topic, shift attitude among individuals through key messages, enhance perceptions regarding favorable norms for FP and support the development of intention among key audiences targeted through the drama serial.

1.3.2. Public Service Announcements (PSAs): PWD will organize and distribute the vast repository of video messaging already available and compliment these with development and dissemination of

Public Service Announcements (PSA) developed for different key messages and record popular opinion leader and role model testimonials on key behavior themes. Incorporating validated key messages (described above), additional content will be developed to encourage and motivate individuals to develop intention, provide correct information and cues to action, and to promote health literacy regarding key behavior themes among individuals for promoting timely adoption of timely health-seeking behaviors by individuals. Each PSA will be developed in print, audio-video and audio alone formats for dissemination through television, print, and digital media.

1.3.3. Animated Videos: To promote key behaviors related to family planning, maternal and child health and nutrition, animated videos will be developed and disseminated. These videos will be designed to effectively address the existing barriers and encourage the adoption of priority behaviors.

1.3.4. Television Talk Shows: Panel discussions on different themes and topics related to communication objectives will be organized with opinion leaders, experts and service providers and recorded for local cable television. The format of the shows will include scripted call-in questions and testimonials from early behavior adopters. The strategy will explore and develop an interactive call-in feature and engage opinion leaders in these conversations.

1.3.5. Campaign messaging and Storytelling through Print Media: To effectively deliver key messages through print media, PWD will collaborate with partners to develop and publish content through various print media channels, including campaign features that focus on women during international days. Additionally, PWD will facilitate engagement with popular women-facing periodicals, such as Akhbar i Jahan and others, to publish human interest stories that incorporate key messages on FP. These stories will be delivered using dramatic relief through storytelling, ensuring maximum engagement and impact among the target audience.

Key Activities

i. **Development of a FP/RH Campaign Design:** PWD will collaborate with development partners and private sector stakeholders to develop a creative campaign design, encompassing marketing materials, campaign slogans, and branding tailored to the target audience. This will ensure that all messaging is consistent, and delivery of IEC is able to capture, captivate, and engage audiences in a manner where messages reinforce each other.

ii. **Development of mass media content:** PWD will collaborate with partners to distribute existing PWD content and develop additional mass media content guided by the campaign design described above. This content will encompass various formats described above, such as print, audio, and audio-video, with a specific focus on integrating key messages that promote FP/RH behaviors. Collaborative efforts will ensure that the content is comprehensive, engaging, and culturally appropriate for the target audience.

iii. **Content testing, validation, and approval:** Following the development of mass media content, the next crucial step involves testing, validating, and obtaining consensus for dissemination. This process ensures that the content is culturally congruent and effectively conveys the intended messages. Input from DoH and other relevant departments as well as development partners will be sought during this phase to ensure that the content aligns with public health priorities, guidelines, and regulations. Upon validation and approval by competent authority, the content will be deemed ready for dissemination through print media channels.

This rigorous validation process ensures that the content effectively reaches the target audience and contributes to promoting target FP/RH behaviors among women in target communities.

iv. Dissemination through provincial partners: In addition to developing and validating content, PWD will work closely with partners to facilitate widespread dissemination of approved material. Collaborating with local partners ensures that the content reaches the target audience effectively and efficiently. Through this collaboration, PWD aims to utilize existing networks and channels within the province to maximize the reach and impact of key messages. By working closely with provincial partners, PWD ensures that the agreed upon content is disseminated widely and consistently across stakeholders.

1.4. SOCIAL MEDIA

PWD's social media strategy will be positioned as a supportive channel of communication for all activities described above. Content from previously described channels including core key messages, audio-video/audio/print PSAs, community signposting messages, opinion leader and role model testimonials and graduation awards for role model households, advertisements for community events, information on available Helplines and other sources of health information, products, and services, will be disseminated using the following approaches.

1.4.1. Standard social media: Targeted content from sources described above will be developed, adapted, and planned for daily, weekly, and monthly dissemination across a full range of platforms including Facebook, X, Instagram, Snapchat, TikTok, and YouTube. This will include dissemination of existing content already produced by PWD.

1.4.2. Virtual Social Networks: Virtual social networks will be created, managed, and moderated by Community Champions and Advocates using the most prevalent communication applications. Virtual social networks will be created separately for individual audience segments described above. Champions will disseminate content generated for social media as digital IEC through these local, virtual social networks with a twofold objective: to engage individual sub-segments through digital IEC and social media links with key messages, and to further cascade content through community networks and virtual family and friends' groups. WhatsApp, Telegram, Botim, and Signal will be explored for feasibility and the most widely used applications will be used. Support will be sought from development partners in leveraging and expanding networks of community champions, including youth champions.

1.4.3. TikTok Stars and Social Media Influencers: Two approaches will be considered for more infotainment-based delivery of key messages through engagement of TikTok Stars and Social Media Influencers (SMIs).

1.4.3.1. TikTok Star and SMI-led brief campaigns: PWD, with support from development partners will identify and recruit local TikTok stars and SMIs to develop and share reels and content for brief social media campaigns on FP/RH. As before these will be synced with international health days and reinforce other messaging sources. Leveraging local creativity and influence, TikTok Stars and SMIs will be facilitated in co-designing content which incorporates key messages, FP/RH Campaign design, content from other channels, and provides linkages with formal information sources.

1.4.3.2. TikTok Star Challenge: PWD with partners will collaborate with key stars and SMIs to co-design engaging and fun TikTok and social media challenges to raise awareness on and build salience of FP/RH behaviors. These challenges will be linked to other brief campaigns and will be led by TikTok Stars and SMIs recruited and mobilized by PWD and development partners.

Key Activities

i. Social Media Integration: PWD will integrate content from the provincial signposting approach into its social media strategy, ensuring collaboration, review, and approval by public and private sector stakeholders at each step of the activity. This involves developing targeted content adapted from signposting materials for daily, weekly, and monthly dissemination across various social media platforms such as Facebook, Instagram, Snapchat, TikTok, and YouTube.

ii. Establishment of Virtual Social Networks: Virtual social networks will be established and managed by Community Champions and Advocates in close collaboration with development partners, leveraging existing investments in SBC for FP in Punjab. Utilizing prevalent communication applications such as WhatsApp, Telegram, Botim, and Signal, these networks will cater to specific audience segments identified through the provincial signposting approach. Champions and Advocates will disseminate digital content derived from signposting messages within these virtual networks, engaging individuals and cascading information through community networks and virtual family and friends' groups under the guidance and oversight of PWD.

iii. Engagement with TikTok Stars and Social Media Influencers: PWD will collaborate with local TikTok stars and Social Media Influencers (SMIs) in partnership with development partners, ensuring collaboration, and consensus at each stage of the activity. This collaboration involves recruiting and mobilizing TikTok stars and SMIs to create reels and content for brief social media campaigns and challenges focused on key behavior themes derived from the provincial signposting approach. Content will be synced with international health days and reinforced through other messaging sources to enhance its impact and reach across social media platforms. Additionally, PWD will facilitate co-designing of content with TikTok stars and SMIs, ensuring alignment with key messages and linkages with formal information sources, with the endorsement and approval of government representatives.

1.5. TARGETED SMS CAMPAIGNS FOR KEY THEMES AND BEHAVIORS

Through rigorous testing and adaptation processes, PWD aims to harness the potential of mobile technology to deliver targeted messages, reaching individuals at critical points in their reproductive health journey. By integrating SMS-based mHealth strategies into its broader communication efforts, PWD Punjab seeks to enhance access to essential health information and services, ultimately contributing to improved maternal and child health outcomes in the target communities. Two approaches are proposed.

PWD, in collaboration with its partners in the SBC Working Group, will undertake the development of a comprehensive theme-based SMS campaign aimed at disseminating key messages related to behavior change objectives. This campaign will be strategically designed to utilize regular, intermittent SMS communication, ensuring the consistent delivery of key messages to the target audience. Over the course of a year, three distinct campaigns will be developed, with each campaign aligned with an international health day, thus capitalizing on existing awareness and momentum. To maximize impact, each campaign will be launched 60 days prior to the respective International Health Day, gradually building anticipation and engagement leading up to the event. Throughout the duration of each campaign, a daily key message relevant to the designated theme will be delivered via SMS to recipients. Importantly, separate campaigns will be tailored for men and their household influencers, recognizing the importance of engaging both groups simultaneously to foster behavior change by women at the individual level.

Key Activities

i. Development, Testing, Validation, and Approval of SMS Messages: PWD, along with its partners, will develop SMS messages aligned with behavior change objectives. These messages will undergo rigorous testing, validation, and review processes to ensure effectiveness and cultural appropriateness. These will be shared with all stakeholders and partners for deployment.

ii. Action Planning and Annual Campaign Plan Development: PWD and partners will collaboratively develop action plans and an annual SMS campaign strategy. These plans will outline thematic focuses, messaging strategies, and dissemination approaches for the SMS campaigns. Collaborative input will be sought to ensure alignment with provincial health priorities and to garner support for implementation.

iii. Dissemination in Collaboration with Partners as per Planned Timeline: PWD will work closely with stakeholders and development partners to execute the SMS campaigns according to the planned timeline. This involves coordinating dissemination efforts, monitoring progress, and adjusting strategies as needed. Collaborative efforts will ensure that SMS messages are effectively delivered to the target audience through a wide range of actors, maximizing the impact of the campaigns.

2. Strategies for facilitating adoption and maintenance of behaviors among individuals

2.1. STRATEGIES FOR IMPROVING KNOWLEDGE AND SKILLS AMONG INDIVIDUALS

2.1.1. Improved knowledge and skills among Adolescents and Youth

Strategies for engaging female youth at universities in Punjab aim to enhance their knowledge regarding family planning and reproductive health through a series of strategic activities guided by a comprehensive annual operational plan. Priority initiatives are described below.

2.1.1.1. Premarital Counseling program: As part of the effort to provide targeted educational interventions, and under the aegis of the PWD, a robust program of pre-marital counseling will be

developed with technical assistance from development partners in the SBC Working Group. Delivered through nikah khawans and/or nikah registrars the intervention will be pursued in coordination with local government and in collaboration with Local Government and Community Development Department, and the Higher Education Department. Operational modalities will be defined during Phase 2 of the implementation framework.

These sessions will be designed to offer essential guidance on family planning, particularly PPFP, and reproductive health, helping youth make informed decisions as they prepare for marriage. The counseling sessions will be tailored to address the specific needs and concerns of young women and their partners, providing them with the knowledge and resources necessary for a healthy start to married life.

2.1.1.2. Establishing University Partnerships: As a critical step in this plan, partnerships will be established with 25 universities, including prominent institutions such as GCU Lahore, LCWU Lahore, Kinnaird College Lahore, KEMU Lahore, and LUMS Lahore, among others. These partnerships are crucial for gaining the necessary access and support from the universities to implement the various initiatives aimed at improving knowledge about family planning and reproductive health among female students.

2.1.1.3. University Sports Events with Key Messaging: Another key activity involves the development, testing, validation, and printing of branding materials for university sports events, which will be specifically designed to convey important messages related to family planning and reproductive health. These events will be hosted at the 25 partnered universities and will include popular sports such as cricket, football, wrestling, kabaddi, and other indoor sports. The branding at these events will ensure that the key messages reach a broad and diverse audience, leveraging the popularity of sports to engage female students effectively.

2.1.1.4. Seminars, Conferences, and Informative Lectures: In addition to sports events the action plan includes the organization of seminars and conferences at the universities, where key themes related to family planning and reproductive health will be prominently featured. These events will serve as platforms for in-depth discussions and knowledge sharing among students, educators, and health professionals. Complementing these efforts, informative lectures will be delivered at colleges and universities, focusing on the critical themes identified in the plan. These lectures aim to reinforce the knowledge imparted through other activities, ensuring that the message is consistently communicated across various platforms and events.

2.1.2. Improved knowledge and skills among MWRA

Messages to improve health literacy, knowledge about sources of information and services, and how to access these will be embedded in all communication and engagement activities aimed at reaching MWRA. Any message aimed at shifting attitudes, perceptions of norms or perceptions of personal agency will be sequentially combined with appropriate information on where to access more information, or access products and services for FPRH. Please see the section above for interventional approaches where knowledge-specific messages will be distributed to MWRA.

2.2. STRATEGIES FOR REDUCING ENVIRONMENTAL CONSTRAINTS AND IMPROVING SERVICE AVAILABILITY

2.2.1. Improved availability of FP services through community-based providers:

2.2.1.1. Deployment of Private sector Community Health Workers in uncovered areas:

To extend the reach of community-based health education approaches CHWs supported through private sector partners will be deployed in areas not covered by LHW program. During the first phase of implementation 150 female health workers will be deployed for expanding access to family planning in urban slums and rural areas. These CHWs will be linked to supply-side private sector engagement initiatives for expanding access to family planning services including social marketing, and vouchers for BISP beneficiaries linked to franchising.

2.2.1.2. Deployment of Community Volunteers to Support health workers: Collaborating with Community-Based Organizations (CBOs) and development partners, Community Volunteers under the PWD will be strategically deployed to assist LHWs and other field cadres included private sector CHWs in organizing community-based activities described earlier. These volunteers will play a crucial role in engaging with individuals within their communities, facilitating discussions on family planning, and addressing misconceptions or concerns regarding contraception and fostering greater community involvement and awareness. 1,250 Community Volunteers will be deployed in areas of need including both female and male volunteers (please see strategy 1.2)

2.2.1.3. Training and Empowering field health workers and Community Volunteers in delivering family planning services: Field health workers and Community Volunteers will be supported through comprehensive training sessions aimed at equipping them with the necessary knowledge and skills to deliver family planning information, products and services for short term methods, and referrals in community settings.

2.1.2.4. Ensure Community Outreach through Camps: Community outreach and female family planning camps will be organized under the banner of PWD for provision of information, products, and services related to modern FP. This activity will be undertaken jointly with development partners and linked to CBO-led community-based activities for demand generation and provision of referrals. Given funding limitations available to support frequent outreach camps, donor supported investments will be leveraged through development partners.

2.2.2. Improved availability of FP services through facility-based providers

2.2.2.1. Increased availability of family planning services delivered by the private health sector: Established and demonstrably effective models for improving availability of family planning services, particularly through community-based private providers (Lady Health Visitors and Community Midwives), will be introduced in areas not covered by the LHW program. Social Marketing linked with fractional clinical franchising will be adapted for 11 districts with high need in southern Punjab. These will be linked to and support private sector CHWs described earlier.

2.2.2.2. Improved equity through family planning vouchers: Demand-side financing for family planning through voucher schemes is a powerful behavior change tool for family planning, particularly for women from poor households who lack the ability to pay for transport and/or

services. To ensure effective targeting, voucher schemes will be designed primarily for BISP beneficiaries and vouchers will be redeemable for transport and/or services at both public sector and franchised private sector facilities.

2.2.2.3. Strengthened Referral Systems: Province-wide, district-level referral systems will be reviewed for identifying gaps and defining referral processes and procedures for ensuring a continuum of care for family planning adoption and continued use. This referral system will serve to link community-based demand mobilization with facility-based services. Additionally, efforts will be directed towards developing a Management Information System (MIS) to record and report all SBC engagement activities. A validation plan will be put in place to ensure the accuracy and reliability of the data recorded in the MIS. The role of development partners with existing investment in SBC for FP will be leveraged to complement PWD investments.

2.2.2.4. Tailored IPC delivered in clinical settings: Linking to the provider behavior change (PBC) strategy, intending audiences who initiate target behaviors and access services will be supported by healthcare service providers who will deliver gender, and youth responsive, respectful, person-centered counseling to facilitate informed choice and provision of indicated clinical care. Please see section 3.1. on PBC.

SOCIAL MARKETING THROUGH DIGITAL HEALTH PROVIDER NETWORKS SUPPORTED BY E-COMMERCE

The strategy will also explore linking social marketing, particularly for short-term methods, with existing, self-sustaining networks of digitally linked service providers, particularly for youth who are able to pay for services. Existing solutions offer low-cost, rapidly scalable interventions, such as the BOLO Health Digital Youth Marketplace for Family Planning, operated by Oladoc

PPFP INTEGRATION ACROSS STRATEGIES

The strategy will integrate PPFP as a thematic focus area across all strategies and interventional channels.

- Targeted key messages and IEC materials for a Multi-channel **PPFP campaign** designed to support all strategies.
- Program integration of community based and mass/social media campaigns with **service delivery** interventions described under Strategy 1.1 and 1.2.
    - Public sector service delivery points through PWD and IRMNCH health worker cadres.
    - Private sector service delivery points through CHWs supported by social marketing and vouchers linked to franchising.
- Endorsement by **opinion leaders and societal influencers** under Strategy 2 and 3.1.
- Complemented by **provider behavior change intervention "Nai Umang"** for PPFP under Strategy 3.2.
- Prioritized as a **thematic focus for Stewardship** under Strategy 3.3.

Strategy 1.2: Increased adoption of family planning methods by men

Audience and Target Behaviors

PRIMARY AUDIENCE	MALE YOUTH AND MARRIED MEN (15 YEARS AND OLDER)

AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
UNMARRIED YOUTH (15-29 YEARS)	• Seek age and life stage appropriate information for family planning • Utilize age and life stage appropriate sexual and reproductive health services
NEWLY MARRIED MEN	• Adopt a male method for family planning (withdrawal or condoms) for delaying first pregnancy / preventing unplanned pregnancy.
EXPECTING HUSBANDS AND FATHERS	• Adopt male method for family planning (withdrawal or condoms) post-partum for preventing unplanned pregnancy and delaying next pregnancy.
FATHERS WHO WANT MORE CHILDREN	• Adopt male method for family planning (withdrawal or condoms) for preventing unplanned pregnancy and delaying next pregnancy.
MEN WHO HAVE COMPLETED THEIR FAMILIES AND WANT NO MORE CHILDREN	• Adopt male sterilization (non-surgical vasectomy) for preventing unintended pregnancy.

Communication & Engagement objectives

I. **Build Intention:** Men develop expectations and intention to adopt a male family planning method.

a. **Improved Attitude:**
   i. Male Youth and Men feel comfortable about using a male family planning method.
   ii. Male Youth and Men believe that using a male family planning method will lead to better health outcome for self and family.
   iii. Male Youth and Men believe that modern male family planning methods are safe and effective for birth spacing.
   iv. Male Youth and Men believe that not practicing family planning by men can lead to significant harm to self and child and incur high healthcare expenses to manage.

b. **Improved Perceived Norm:**
   i. Male Youth and Men believe that their peers and other men in their community are also using a male family planning method.
   ii. Male Youth and Men believe that their mothers will support them in using a male family planning method.

c. **Improved Personal Agency:**

i. Male Youth and Men do not perceive any major environmental barriers to using a male family planning method.
ii. Male Youth and Men are confident in being able talk to a service provider for adopting a male family planning method.

II. **Promote Adoption of target behaviors by intending Men**

a. **Improved Knowledge and Skills:** Male Youth and Men have correct knowledge and skills for accessing FP/RH information, products, and services for completing target behavior.
b. **No Environmental Constraints:** Male Youth and Men can access transport, travel to health facility, pay for services, and negotiate respectful, gender sensitive male family planning care from providers/facilities.
c. **Cues-to-action:** Male Youth and Men understand and apply learnings from IEC materials and want to redeem referrals.

Interventional Approach and Activities

1. Strategies for Building Intention among individuals

1.1. COMMUNITY-BASED HEALTH EDUCATION

Male Family Welfare Assistants (FWAs), Male Social Mobilizers, Male Motivators, and male CHWs in uncovered areas will be the primary channels for engaging men as users of modern family planning methods. The approach to engagement will build on existing established modalities of community-based engagement and include:

1.1.1. Male Community meetings: Targeted messaging through small group neighborhood meetings with men, using PRA tools such as social mapping, discussions with and information sharing by peer role models, and opinion leaders. Following a similar approach, navigating through these PRA tools used in inter-personal settings will help to establish common construal of meaning and develop stronger descriptive norms for target behaviors among men. Government approved behavior change communication toolkit "Sehat Ki Dastak" will be used.

1.1.2. Husbands' Forum: Husbands' Forum is a community-based, SBC intervention, that is designed to improve family planning and reproductive health and address gender-based barriers that contribute to poor health outcomes. Husbands' Forum is not only designed to address the significant barrier of men preventing their wives from accessing health services but also to create a socio-normative environment where men can actively participate in health promotion, particularly in family planning. This aim is to engage the larger community in supporting the use of reproductive health services and encourage increased sharing and decision-making within couples. Leveraging the Tawazun framework, the strategy of the Husbands' Forum intervention focuses on training and reinforcing the knowledge of husbands on the importance of promoting and using family planning services and reproductive health services – antenatal and assisted delivery.

Key Activities

i. Validation of key messages for boys and men as FP users: Guided by the theory of change and evidence-based communication and engagement objectives, PWD will support the development, testing, and validation of a comprehensive set of key messages for men as users of FP. This will be in collaboration with development partners and will ensure consistency of messaging across channels and partners. These validated messages for different themes will inform the IEC approach and content created for dissemination through a wide range of community-based health education.

ii. Development of tailored IEC materials and job aids: PWD will collaborate with development partners to support the development of male-facing IEC materials (e.g., flyers, leaflets, checklists, etc.) for use in both household and community-group settings. PWD will also develop updated job aids for male health educators (e.g., participatory engagement tools, field support manuals with health educator scripts, counseling flipbooks, visiting cards, etc.) to incorporate validated key messages for key themes and participatory approaches in existing cadres of community-based male health educators.

iii. Training and capacity development of community-based health educators: PWD will collaborate with DoH, and development partners to undertake training and capacity development of male mobilizers, male FWAs, and male CHWs in uncovered areas, to develop capacity and equip with IEC materials and job-aids for delivering health promoting information, products, services, and referrals for key themes. The activity will focus on developing a pool of male master trainers for step-down cascade training for relevant cadres.

iv. Strengthen supportive supervision and synergy across cadres: PWD, with support from development partners, will conduct a thorough review of the current systems in place for the supportive supervision of key cadres of male community-based health educators. This review may result in deploying supervisors and providing training to existing supervisors on updated IEC materials and job aids, as well as addressing any gaps in the current supervisory mechanisms, focusing on PWDs male FWAs. Mechanisms will also be identified to support improved synergies across the different cadres, including through standardization of messages and IEC materials. Collaboration with the DoH and other development partners will be integral to this process.

1.2. COMMUNITY SIGNPOSTING

Same as explained above under Intervention approach & activities of **strategy 1.1.** but using the set of messages and content developed specifically for men.

1.3. SBC THROUGH MASS MEDIA

Same as explained above under Intervention approach & activities of **strategy 1.1.** but using the set of messages and content developed specifically for men.

1.4. SOCIAL MEDIA

Same as explained above under Intervention approach & activities of **strategy 1.1** but using the set of messages and content developed specifically for men.

1.5. SMS-BASED SBC FOR KEY THEMES AND BEHAVIORS

Same as explained above under Intervention approach & activities of **strategy 1.1** but using the set of messages and content developed specifically for men.

2. Strategies for facilitating adoption and maintenance of behaviors among individuals

2.1. STRATEGIES FOR IMPROVING KNOWLEDGE AND SKILLS AMONG INDIVIDUALS

2.1.1. Improved Knowledge and Skills Among Adolescents and Youth

Strategies for engaging male youth at universities in Punjab will run in tandem with the overarching strategy for youth engagement described for female youth under Strategy 1.1. As described earlier strategies include Premarital Counseling program, University partnerships for youth educational seminars, conferences, and lectures and student engagement through sports events. Please refer to Strategy 1.1 for an overview.

2.1.2. Improved Knowledge and Skills Among Married Men

Messages to improve health literacy, knowledge about sources of information and services, and how to access these will be embedded in all communication and engagement activities aimed at reaching men. Any message aimed at shifting attitudes, perceptions of norms or perceptions of personal agency will be sequentially combined with appropriate information on where to access more information, or access products and services for male and female family planning. Please see Strategy 1.1 for interventional approaches where knowledge-specific messages for men will be distributed.

2.2. STRATEGIES FOR REDUCING ENVIRONMENTAL CONSTRAINTS AND IMPROVING SERVICE AVAILABILITY MEN

2.2.1. Improved availability of male FP services through community-based providers

2.2.1.1. Deployment of Male Health Volunteers to Support Lady Health Workers: Collaborating with Community-Based Organizations (CBOs) and development partners, Male Health Volunteers under the PWD will be strategically deployed to assist LHWs in organizing male community meetings. These volunteers will play a crucial role in engaging with men within their communities, facilitating discussions on family planning, and addressing misconceptions or concerns regarding male contraception. By working closely with LHWs, Male Health Volunteers will enhance the reach and effectiveness of male-focused health interventions, fostering greater community involvement and awareness.

2.2.1.2. Training and Empowering LHWs and Male Health Volunteers in Male-Focused Family Planning: LHWs and Male Health Volunteers will be supported through comprehensive training sessions aimed at equipping them with the necessary knowledge and skills to deliver male-focused family planning information, products, services, and referrals in community settings. These training programs emphasize the importance of addressing male reproductive health needs and promoting gender-inclusive approaches to family planning. By strengthening the capacity of frontline male healthcare workers and volunteers, this initiative aims to enhance access to male contraceptive options and empower individuals and couples to make informed reproductive health decisions.

2.2.1.3. Ensure Community Outreach through Camps: Community outreach and male family planning camps will be organized under the banner of PWD for provision of NSV. This activity will be

undertaken jointly by PWD and development partners and linked to CBO-led community-based activities for demand generation and provision of referrals.

2.2.2. Improved availability of male FP services in facility-based providers:

2.2.2.1. Strengthen Referral Systems: Province-wide, district-level referral systems will be reviewed for identifying gaps and defining referral processes and procedures for ensuring a continuum of care for men adopting male contraceptive methods for family planning. This referral system will serve to link community-based demand mobilization for male contraception with facility-based services through male service providers (please see next activity). Additionally, efforts will be directed towards developing a MIS to record and report all male engagement SBC activities. A validation plan will be put in place to ensure the accuracy and reliability of the data recorded in the MIS.

2.2.2.2. Strengthen, support, and expand facility-based delivery of male FP information, products, and services: In collaboration with development partners, professional associations, and Social Marketing Organizations (SMOs), male general practitioners and family physicians in Punjab will be trained on delivering male contraceptive information, products, services, and referrals. PWD will also collaborate with professional associations and SMOs, to train and equip lady doctors and gynecologists to provide couples counseling inclusive of male contraceptive methods and referrals. Please see Strategy 1.1 for an overview of the social marketing component of the strategy.

2.2.2.3. Urologist and Surgeon Training on NSV: PWD will also explore training public and private sector urologists and surgeons in providing NSV services in Punjab. Collaborating with development partners, both public and private sector urologists and surgeons will be engaged in specialized training programs focused on providing No-Scalpel Vasectomy (NSV) services. These training sessions aim to enhance their proficiency in performing NSV procedures, ensuring safe and effective male sterilization options for individuals seeking permanent contraception. By fostering partnerships with skilled healthcare professionals, this initiative strives to expand access to NSV services and promote reproductive autonomy among men and women.

2.2.2.4. Empowering Alternative Medicine Practitioners in Male Contraceptive Services: Through collaboration with professional associations and SMOs, PWD will organize specialized training opportunities for hakeems, homeopaths, and faith healers to deliver FP/RH counseling and referrals for services. These initiatives are designed to enable alternative health practitioners to deliver male contraceptive information, products, services, and referrals within their respective allowed scope of work, in their communities. By leveraging the reach and influence of alternative health practitioners, this collaborative effort aims to broaden the availability of male contraceptive options and promote informed decision-making among diverse populations.

2.2.2.5. Enhancing Couples Counseling through Gynecologist Training: Through collaboration with professional associations and SMOs, PWD will provide comprehensive training and resources to lady doctors and gynecologists. This training focuses on equipping healthcare providers with the skills and knowledge necessary to offer couples counseling inclusive of male contraceptive methods and referrals. By integrating male contraception into counseling sessions, gynecologists will ensure that couples have access to a full range of family planning options, fostering informed decision-making and mutual understanding. Through this collaborative approach, healthcare providers play a pivotal role in promoting gender-equitable reproductive health services and supporting couples in their contraceptive choices.

Gender and Youth Considerations

Adolescents and Young Women

- Social norms create barriers to meaningful dialogue and communication between parents and daughters and amongst siblings on a very wide range of health and well-being related subjects. Gender norms and stereotypes can limit girls' access to age and life stage appropriate health information and services. Shame and embarrassment around basic health issues including adolescent health issues and psychological distress can hinder activation of existing support systems for girls in their relationships and networks. Privacy and confidentiality concerns may keep girls from seeking age and life-stage appropriate health information and services. Finally geographic, economic, and social barriers limit access to health information and services. SBC strategies should be designed to address these barriers and to provide information to young girls on how to overcome perceived barriers.
- Program should ensure cultural congruence and acceptability by prioritizing locally led and community owned approaches.
- Participatory engagement of AY Champions should be structured, and life-skills based, to mobilize and engage girls through school-based, supervised health promotion activities.
- Multi-channel digital messaging and community salience to support messages should be considered foundational elements to reach girls with age-appropriate, culturally congruent, and stakeholder approved health promotion messages.

Women

- Limited decision-making power in households and communities can affect women's ability to access health information and services. SBC messaging should aim to challenge harmful gender roles and power dynamics by promoting interspousal and household communication on health and well-being and shared decision-making.
- Social and cultural norms can influence women's attitudes and behaviors related to health. Women may be resistant to messaging which challenges conventional, harmful gender roles due to internalization of gender stereotypes. This may be particularly true in relation to social and perceived norms of motherhood. SBC messaging and engagement should therefore focus on:
    - Adopting simple participatory tools to facilitate women in improving critical consciousness and identifying discrepancies between existing social norms of motherhood and recommended principals of motherhood.
    - Favorably influencing women's self-construal as being connected to health promoting behaviors by enhancing perceptions of how common these behaviors are among their peers. This can be achieved by facilitating participatory dialogue in small group settings, followed by reinforcement of new self-construal through household and community-based messaging.
    - Highlight social approval testimonials and endorsements supporting key messages prominently and visibly using channels most likely to reach women. Channels will be selected on their proven ability to reach the intended audience.
    - Women may be reluctant to seek health information and services due to concerns about privacy and confidentiality. SBC messaging should emphasize the importance of confidentiality and ensure services are provided in a safe, private environment.
- Geographic, economic, and social barriers limit access to health information and services. SBC messaging should address these barriers and provide information on how to overcome them,

such as location of health services or how to access financial support. Active linkages need to be ensured by providing cues-to-action linking them to trusted and community endorsed sources of information and services, or support.

Adolescents and Young Men

- Social norms create barriers to meaningful dialogue and communication between parents and sons on a very wide range of health and well-being related subjects. Gender norms and stereotypes also limit boys' access to age and life-stage appropriate health information and services. Shame and embarrassment around basic health issues including psychological distress can hinder activation of existing support systems in relationships and networks. privacy and confidentiality concerns may keep boys from seeking age and life-stage appropriate health information and services. Finally, geographic, economic, and social barriers limit access to health information and services.
- The socialization of boys in patriarchal societies enforces emotional suppression, with anger being the only potentially socially acceptable emotion for boys. Patriarchal socialization of boys often normalizes violence against girls and women, and against other boys and men. SBC messaging should address these traditional stereotypes of men and facilitate boys in redefining the socially approved role for boys, nurture emotional recognition and expression and promote relational well-being through improved household-level communication.
- Boys with positive male role models are more likely than those without them to question harmful gender stereotypes and inequalities. Promoting positive AY development and transforming perceived gender norms can help young men to address their own health needs and support the right of women and girls to attain theirs.

Men

- Traditional stereotypes of gender roles for men create very strong perceived barriers for men in authentically recognizing and expressing psychological distress and seeking social support, particularly around mental health management. SBC strategies should focus on creating and increasing visibility of positive role models and endorsements by community influencers to encourage men to destigmatize mental health and normalize timely care seeking and support for men.

Communication Materials and Content for Delivering the Strategy

Supporting individual behavior change through diverse communication channels necessitates a meticulous approach in providing tailored materials and content. Fieldworker-led sessions in both individual and group settings require an array of resources, including Standard Operating Procedures (SOPs), Participatory Rural Appraisal (PRA) tools, guides, scripts, and IEC materials. These materials ensure effective communication, engagement, and comprehension of key messages among participants. Equally important is the provision of service provider job aids categorized by thematic areas to enhance the capacity of healthcare providers in delivering accurate information and services. Additionally, community signposting initiatives utilize banners, billboards, and branded vehicles to increase visibility and direct individuals to relevant facilities, fostering awareness and accessibility within communities.

Broadcasting platforms such as local cable television will need to be leveraged to disseminate scripted Audio/Video Public Service Announcements (PSAs), talk shows, and documentary shorts,

engaging viewers and communicating information on key thematic areas. A comprehensive social media strategy is needed to effectively utilize online platforms, including content development, SOPs for managing virtual WhatsApp networks, and tailored IEC content. Furthermore, theme-based SMS messages and an annual SMS campaign plan are needed to ensure consistent messaging and outreach, maximizing the impact of communication efforts across all channels. By providing targeted and tailored materials and content across these channels, the strategy aims to effectively communicate key messages, engage individuals, and ultimately facilitate positive FP/RH behavior within the target population. Please see Table 3 below for an overview of these materials.

Table 13: Materials and Content needed for different channels for supporting individual behavior change

S. No.	CHANNELS	MATERIALS
1	Fieldworker-led SBC in individual and group settings	• SOPs, PRA tools, guides, and scripts for activities. • IEC materials by thematic area in local language. • Referral slips.
2	Service provider	• Service provider job-aids by thematic area
3	Community signposting	• Banners, Billboards, and Community signposting branded vehicles and signposting for facilities
4	Local Cable Television	• Scripted Audio/Video PSAs • Broadcast plan for Talk Shows
5	Helpline	• Branded content and creative design or cobranding across all materials and themes.
6	Social media	• Social media strategy and content • Activity SOP and plan for Virtual WhatsApp networks • IEC content including AV
7	SMS	• SMS messages set by theme and behaviors • Annual SMS campaign plan

Strategy 2

Shift household, community, and institutional social and gender norms to improve male engagement and reinforce individual agency and behavior change.

Household Audience and Target Behaviors

PRIMARY AUDIENCE	FAMILY MEMBER KEY INFLUENCERS (FMKIs)

AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
HUSBANDS	• Engage in inter-spousal communication (ISC) for discussing health planning for the family. • Support adoption and maintenance of key health-promoting behaviors related to FP/RH
MOTHERS-IN-LAW	• Encourage son to engage in inter-spousal communication (ISC) for discussing health planning for the family. • Support adoption and maintenance of key health-promoting behaviors related to FP/RH

Household Communication & Engagement Objectives

I. **Create Descriptive Norm:** FMKIs for individuals, believe that other influencers engage in the target behaviors.

II. **Create Favorable Normative Mechanism:** to promote adoption of behavior through the following objectives:

a. **Shift Injunctive Norm:** FMKIs for individuals believe that people important to them expect them to adopt the target behaviors.
b. **Improve Outcome Expectation:** FMKIs for individuals believe that the outcomes of adopting target behaviors have substantive benefits for self, others, and community at large.
c. **Strengthen Group Identity: FMKIs for individuals:**
   - Have high aspirations for their family.
   - Develop shared values with role models.
   - Believe that their values require that they support the target behavior.

Community Audience and Target Behaviors

PRIMARY AUDIENCE	COMMUNITY POPULAR OPINION LEADERS (CPOLs)

AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
COMMUNITY ELDERS AND INFLUENCERS • RELIGIOUS SCHOLARS • CLERGY AND IMAMS • CLAN CHIEFS • PARLIAMENTARIANS • COUNCILORS • TEACHERS • POLITICAL AND SOCIAL ACTIVISTS	• Endorse publicly, PWD FP/RH messages and activities • Encourage men to engage in inter-spousal communication (ISC) for discussing health planning for the family and Support adoption and maintenance of key health promoting behaviors related to FP/RH • Encourage mothers in law to support inter-spousal communication (ISC) for discussing health planning for the family and adoption and maintenance of key health promoting behaviors related to FP/RH.

Community Communication & Engagement Objectives

I. **Create Descriptive Norm:** CPOLs for individuals believe that other influencers engage in the target behaviors.

II. **Create Favorable Normative Mechanism:** to promote adoption of behavior through the following objectives:

a. **Shift Injunctive Norm:** CPOLs believe that they are expected to practice the target behaviors, and these are socially approved.

b. **Improve Outcome Expectation:** CPOLs believe that the outcomes of endorsing target behaviors for men, women, and families will have substantive benefits for others, and community at large. CPOLs also believe that supporting community health positions them for recognition of their leadership in the community.

c. **Strengthen Group Identity:** FMKIs for individuals:
   - Have high aspirations for their family.
   - Develop shared values with role models.
   - Believe that their values require that they support the target behavior.

Policy & Institutional Audiences and Target Behaviors

PRIMARY AUDIENCE	OFFICE BEARERS (OBs)

AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
POLICY MAKERS, MINISTERS FOR HEALTH, EDUCATION, YOUTH, HUMAN RIGHTS, MEMBERS OF PARLIAMENT	• Endorse a gender sensitive lens for supporting adoption of health promoting FP/RH behaviors. • Endorse PWD messages and activities.
SENIOR BUREAUCRATS AT PROVINCIAL LEVEL	
DISTRICT OFFICIALS	

Policy & Institutional Communication & Engagement Objectives

I. **Create Descriptive Norm:** OBs believe that their peers and other office bearers engage in the target behaviors.

II. **Create Favorable Normative Mechanism:** to promote adoption of behavior through the following objectives:

a. **Shift Injunctive Norm:** OBs believe that they are expected to practice the target behaviors, and these are socially approved.

b. **Improve Outcome Expectation:** OBs believe that the outcomes of practicing target behaviors have substantive benefits for individuals, community, and nation at large. OBs also believe that supporting community health positions them for recognition of their leadership in the community.

c. **Strengthen Group Identity:** Officer bearers at different levels:
   - Have high aspirations for their community and area of concern.
   - Develop shared values with role model office bearers.
   - Believe that their position, leadership, and values require that they practice the target behaviors.

Intervention Approach & Activities

This strategy focuses on engaging families (husbands and mothers in law), Community Popular Opinion Leaders (CPOLs), and government office bearers (OBs) as allies and champions supporting and endorsing social and gender norm changes supportive of individuals' target behaviors described in Strategy 1. By targeting injunctive and descriptive norms among these actors the strategy seeks to promote male involvement in family planning, inter-spousal communication, shared decision-making, and endorsement of PWD strategy, messages, and activities for supporting adoption of FP/RH services across Punjab.

1. Movement Building to rally societal influencers as advocates for male involvement in family planning.

This initiative entails several sub-activities and milestones:

i. **Development, testing and validation of key messages for all influencer segments:** Guided by the theory of change and evidence-based communication and engagement objectives described above, PWD will support the development, testing, and validation of a comprehensive set of key messages for the different segmented audiences. This will be undertaken in collaboration with development partners and will ensure consistency of messaging across channels, partners, and investments. These validated messages for different audiences and behaviors will be operationalized through IEC content developed for these audiences.

ii. **Development of tailored IEC materials:** PWD will collaborate with development partners to support the development of influencer-facing IEC materials, e.g. flyers and leaflets, audio, audio-video, and print content for dissemination through a wide range of channels, as described in the previous strategy.

iii. **Development of a Resource Book/Guidance for Norm Shifting Advocates:** A comprehensive resource book will be developed to equip CPOLs with the necessary tools to address socio-cultural norms surrounding FP/RH and male engagement. The resource book will comprise sections outlining harmful norms, rationale for change, and credible endorsements for the new norm, along with guidance on actions influencers can take to promote norm shifting messages in their networks and communities.

iv. **Identification of Societal Influencers:** Societal influencers from diverse backgrounds will be identified at the provincial and district levels, with a focus on religious scholars, clergy, parliamentarians, councilors, teachers, clan chiefs, locally known celebrities, and community gatekeepers. Emphasis will be placed on engaging individuals with significant influence to amplify messages about target behaviors.

iv. **Organization of Dialogue and Action Planning Events:** Regular events will be organized to facilitate dialogue, sensitization, and action planning among societal influencers at provincial and district levels. These events, conducted under the stewardship of the PWD, along with DoH and other departments and supported by development partners, will aim to galvanize support and advocacy for PWD messages and activities for advancing FP/RH. Different policy-level advocacy events will be undertaken to mobilize policy commitments to family planning in Punjab. Implementation-level community-based events will be planned in collaboration with key stakeholders for different audiences. Activities such as Mothers-in-Laws Seminars, Husbands Forum, and district CPOL seminars will be operationalized in collaboration with government teams and partners. Exact modalities and action plan will be developed in consultation with key partners prior to implementation.

2. Community and Media partnerships are leveraged for increasing visibility of societal influencers ' endorsement of new social norms.

Community and Media partnerships serve as instrumental avenues to amplify the endorsement of societal influencers for male contraception, interspousal communication, and shared decision-making by couples to promote adoption of target behaviors at individuals and household levels. This collaborative effort encompasses several strategic initiatives:

i. **Development and Dissemination of Public Service Messages:** Public service messages and testimonials featuring societal influencers and champions will be created to highlight the importance of key behaviors for different audiences. These messages will be disseminated through various media channels such as social media, television, and news outlets, particularly on international days dedicated to women's health, child health, and family planning.

ii. **Organization of Call-in Talk Shows:** Engaging talk shows will be organized on radio and television platforms, providing a platform for discussions on household involvement in male contraception, FP/RH, and the importance of ISC and shared decision making for these behaviors. These call-in talk shows will be designed to encourage audience participation and facilitate dialogue on pertinent issues related to key themes.

iii. **Ensuring High Visibility Media Coverage:** Engaging talk shows will be organized on radio and television platforms, providing a platform for discussions on household involvement in male contraception, FP/RH, and the importance of ISC and shared decision making for these behaviors. These call-in talk shows will be designed to encourage audience participation and facilitate dialogue on pertinent issues related to key themes.

iv. **Male Engagement Events with societal influencers:** Male engagement events will be organized at the provincial, district, and community levels in collaboration with societal influencers. These events will serve as platforms for interactive sessions, workshops, and awareness campaigns (e.g. through community/participatory theater, sports events, local men's forums, and cultural celebrations) aimed at promoting greater ISC, shared decision making, male adoption of family planning, and supporting women's right to utilizing skilled FP/RH care.

v. **Facilitation of Male Inter-generational Dialogues:** Dialogues on population, gender, health, community balance (tawazun), and family planning will be organized in partnership with local institutions and universities, bringing together societal influencers and diverse generations for constructive discussions. These dialogues, facilitated by locally known experts and CPOLs, will actively engage the endorsement and participation of OBs to foster inter-generational exchange of ideas and perspectives, contributing to the promotion of family planning and gender equality.

Gender Considerations

Husbands

- Traditional stereotypes of men position them as decision makers for health-related matters, but simultaneously disconnect them from the issue of FP/RH. SBC strategies should focus on engaging men as gender allies in their roles as supportive fathers and husbands, and agents of change supporting interspousal communication, shared decision making in the household, and the right of women to access skilled, high quality healthcare services for all priority health areas.

- Men may observe and/or directly face social stigma when considering the adoption of new, gender supportive behaviors for being allies. SBC initiative should consider a sequential, top-down approach when being rolled out. This may include obtaining public sector endorsement and testimonials and cultivating community champions to provide social approval for new behaviors for countering emerging stigma or community resistance.
- Gender differences in health-seeking behavior may affect couples' access to services. Men may have limited engagement with the health care system and may not prioritize their own health. SBC strategies should integrate messages around the importance of making healthy decisions for safeguarding the health of all family members including themselves. Please also see gender considerations for men as individuals under strategy 1.
- Traditional stereotypes of men as socially dominant, along with misogyny, a sense of entitlement, polygamy, and patriarchal cultural norms can promote violence, including sexual assault and domestic violence. SBC interventions should address these traditional stereotypes of masculinity and facilitate men in recognizing harmful toxic masculinity and its impact on household well-being, redefining norms of masculinity through critical reflection and role models who promote relational well-being through improved household-level communication.

CPOLs, Mothers-in-law, Household elders and other Family influencers

- Sociocultural norms supported by family influencers will directly impinge upon whether household level communication and shared decision making is promoted. Maintaining social positioning and to maintain reputation and avoid others losing respect for the family are likely to be very important considerations for household influencers, particularly around socially accepted roles for women and men. A top-down approach which highlights government approval and endorsement by community advocates and champions should be considered to create a favorable normative environment for CPOLs, household elders and influencers such as mothers-in-law.
- CPOLs, and household influencers like the mother-in-law may experience awkwardness, embarrassment, and even shame when being encouraged to discuss issues related to FP/RH, and men's adoption of FP. Building social approval and salience of the issues will be a critical first step. Initial direct engagement should support these audiences in developing communication skills, ideally in small "support-group" like settings for also influencing perceived descriptive norms for the behavior.
- Endorsement of key behaviors for household influencers by clergy and scholars should be obtained as early as possible with direct engagement through these influencers for addressing normative religious misconceptions and clarifying social norms that are at odds with religious doctrine.

Communication Materials and Content for Delivering the Strategy

To effectively implement the strategy, a range of resources needs to be developed across various channels. Firstly, for all channels, it's essential to create branding and marking guidelines specific to the PWD FP SBC Strategy, ensuring consistency and clarity in messaging. Additionally, crafting key messages tailored to different audience segments on relevant behaviors is crucial for maximizing impact and resonance. Further, resources aimed at engaging CPOLs, and Societal Influencers are necessary. This includes the development of a comprehensive Resource Book/Guidance tailored specifically for Norm Shifting Advocates, providing them with the necessary tools and insights to drive positive change within their communities.

In terms of community signposting, the production of banners, billboards, and branded vehicles, along with branded signposting for facilities, is essential to guide individuals effectively and ensure visibility of FP/RH services within the community. For Local Cable Television, the creation of scripted Audio/Video PSAs and the development of a broadcast plan for Talk Shows are vital components to leverage this medium effectively and reach a broader audience. On Social Media resources such as a well-defined strategy and engaging content are required to effectively leverage this platform. Additionally, preparing an Activity SOP and plan for Virtual WhatsApp networks is essential for maximizing engagement and dissemination of information. Moreover, the creation of compelling IEC content, including Audio-Visual materials, is crucial for capturing the attention of the target audience and conveying key messages effectively. Lastly, for Community Events, resources should focus on designing and creating branded content for all community event branding, ensuring consistent messaging and visibility across various local events and gatherings.

Table 14 presents an overview of the types of materials and guidance resources needed for different channels described for shifting social and gender norms related to key behavior themes.

Table 14: Materials and Content needed for different channels for supporting Strategy 2

S. No.	CHANNELS	MATERIALS
1	All channels	• PWD SBC Strategy campaign branding and marking guidelines • Key messages for audience segments on relevant behaviors
2	CPOLs and Societal Influencers	• Resource Book/Guidance for Norm Shifting Advocates
3	Community signposting	• Banners, Billboards, and Community signposting through branded vehicles and branded signposting for facilities
4	Local Cable Television	• Scripted Audio/Video PSAs • Broadcast plan for Talk Shows
5	Social media	• Social media strategy and content • Activity SOP and plan for Virtual WhatsApp networks • IEC content including AV
6	Community Events	• Branded content and creative design for all community event branding

Strategy 3

Promote institutional and structural factors that enable healthy decision making among individuals, households, and communities.

Strategy 3 focuses on enhancing the responsiveness of systems to the healthcare rights and needs of the citizens of Punjab, thereby promoting institutional and structural factors that facilitate healthy decision-making among individuals, households, and communities across the province. This involves strengthening community-led social action and inclusion, promoting behavior change among healthcare providers to deliver high-quality, person-centered care, and enhancing stewardship efforts to improve the availability and utilization of FP/RH services. Each of these domains comprises a sub-strategy, and these are described below.

Strategy 3.1: Strengthened Community-led social action, voice, & inclusion for supporting target FP/RH behaviors.

Community-led SBC initiatives are integral to promoting sustainable health outcomes and fostering meaningful community engagement. By entrusting communities with the responsibility to lead SBC efforts, the strategy aims to empower communities to take ownership of their health and well-being. This approach not only enhances the relevance and effectiveness of interventions but also fosters a sense of ownership and pride within communities.

Furthermore, embedding these initiatives within principles of community empowerment and development ensures that interventions are culturally sensitive, contextually relevant, and sustainable in the long term. By prioritizing community voices and agency, the strategy aims to create pathways for collective action, enabling communities to address their unique health challenges and drive positive change from within.

Audience and Target Behaviors

PRIMARY AUDIENCE	COMMUNITY MEMBERS AFFILIATED WITH CBOS

AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
COMMUNITY BASED ORGANIZATIONS (CBO) LEADERS	■ Endorse a gender sensitive lens for supporting FP/RH services for men and women in their communities. ■ Endorse and support PWD FP/RH messages and activities.
COMMUNITY BASED ORGANIZATIONS (CBO) FUNCTIONARIES AND REPRESENTATIVES	■ Lead, support, and facilitate community led SBC and engagement activities for supporting activities described under the PWD SBC Strategy for Punjab.

Communication & Engagement Objectives for Community Empowerment

i. Participation & Relevance: Community stakeholders engage in dialogue that enables them to link root causes and promote critical thought regarding the importance of inter spousal communication for adoption of skilled FP/RH services.

ii. Issue Selection: Community stakeholders identify issues through participation, reflection, and analysis of lived experiences, aspirations and discrepancies between lifestyles and aspirations to identify issues of importance and relevance to inter spousal communication for adoption of skilled FP/RH services.

iii. Social Capital: Community stakeholders collectively improve leadership, social networks, and quality of community life through participatory reflection and dialogue aimed at movement building to address barriers to inter spousal communication for adoption of skilled FP/RH services.

iv. Collective Efficacy: Community stakeholders proactively own and lead social action for SBC related to inter spousal communication for and promoting adoption of skilled FP/RH services.

v. Community Capacity: Community members can lead activities aimed at identifying and solving their problems related to inter spousal communication for adoption of skilled FP/RH services and become better able to address future problems collaboratively.

vi. Empowerment: Community organization, capacity building, and increased critical consciousness for greater power to create desired changes in the issues related to people's health and wellbeing particularly around inter spousal communication for and supporting the adoption of skilled FP/RH service by men and women.

Interventional Approach and Activities

Community engagement approaches for supporting Strategy 3 are designed to support local ownership and promote alignment with principles of participatory health education. Informed by the stages of community development and community building, the approach to community mobilization comprises a set of sequential activities linked to specific engagement objectives described above[1].

The strategy acknowledges that one size does not fit all, and the three-step approach presented below assumes starting from scratch. In communities where initial work has already been undertaken, particularly through development partners, implementing program teams can start from the step most relevant to their community.

These steps are presented below.

[1] Available resources to support development of community social action should be considered to develop a locally developed and adapted approach that is informed by the change hypotheses. These frameworks and approaches include SALT (Constellation), Community Action Cycle (SCF, MC, CGHPI, Breakthrough Action, others), Community Development Cycle (Outreach Int), and others.

1. BUILD CRITICAL CONSCIOUSNESS AND FACILITATE ISSUE SELECTION

Approach

- Ensuring participation and relevance of community stakeholders across all activities.
- Sensitization and awareness creation on gender, gender norms and gender mainstreaming in community leadership.
- Facilitating community dialogues and focus group discussions on FP/RH including harmful gender norms resulting in negative FP/RH outcomes.

Activities

i. CBO mapping and engagement: Sensitization, awareness raising, and activity planning for dialogue activity.
ii. Community Popular Opinion Leader (CPOL) Forum: Multisectoral Dialogues with CPOLs and key stakeholders using existing community group and CBO platforms.
iii. Community target audience group forums: facilitated dialogue in peer-groups of CBO representatives and/or social action groups.

2. BUILD SOCIAL CAPITAL AND ENHANCE COLLECTIVE EFFICACY

Approach

- Expand inclusion of community units.
- Strengthen and support community-based social networks bridging connections across sectors.
- Community groups supported to engage in dialogue and reflection across stakeholders and sectors.

Activities

i. **Capacity building:** PWD will collaborate and coordinate with development partners and other stakeholders to support the provision of short training workshops to build capacity of community leadership and CBOs on key health messaging.

ii. **Community group dialogue:** Following initial capacity building, community stakeholders and CBO representatives will be sensitized using reflection and analysis approach to agree on priority FP/RH issues and behaviors and identify areas for collaboration among groups and across sectors.

iii. **Co-design sessions for social accountability, inclusion, and voice initiatives:** PWD will steward activities for organizing and facilitating dialogue among multi-sectoral actors and CBOs and community groups to agree on a scope of work for social accountability, voice, and inclusion. Groups will be facilitated in reviewing needs and developing Community Dashboards and Community Scorecards (CSC)/Citizens' Report Cards on key community indicators related to FP/RH, and action plans for implementing these initiatives.

iv. **Public private dialogue (PPD):** Integrated within these activities will be activities aimed at strengthening PPD. This would include CBO inclusion in review of existing and new policies and provisions of relevance to expand understanding, identify gaps and opportunities, and cocreate and prioritize solutions for promoting community compliance with recommended norms and health practices.

STEP 3. SUPPORT COMMUNITY CAPACITY AND FACILITATE EMPOWERMENT

Approach

- Support and facilitate CBOs and community groups to plan and implement relevant solutions and strategies identified through dialogue and reflection on priority issues.
- Provide need-based support and thought partnership to CBOs to review progress against planned activities and provide guidance on course correction.
- Advocate for and on behalf of community groups to operate across sectors and link FP/RH efforts with multisectoral and economic empowerment approaches.

Activities

i. **Social Action Planning:** Community groups will be supported in collaboration with development partners and other public sector stakeholders to develop activity plan Social Action Agenda and Action Plans that are aligned with the strategy and available resources. Activity plans will be developed with inclusion and support from LHWs, FWAs, and CHWS.

ii. **Social Action for supporting SBC:** CBOs will lead direct implementation of a range of SBC activities aimed at enhancing community ownership of the localized FP/RH agenda stemming from this strategy. Materials and communication collaterals developed for Strategies 1 and 2 will directly feed into the following activities, with CBOs potentially supporting some of the activities at the community-level described therein. More specifically CBO-led activities would operate at a community level and may include the following, that will be incrementally rolled out. Technical assistance and oversight, and stewardship from PWD would be ongoing during this period.

   a. **Community-led SBC Implementation:** Community groups conduct and implement solutions and host Community Actions Days to implement jointly identified activities in support of FP/RH
   b. **Cultivating Change Agents:** CBOs and community groups recruit, sensitize, and mobilize community leadership to act as transformative change agents (please see Strategy 2).
   c. **Referral linkages:** CBOs identify and lead efforts to strengthen linkage and referrals (Please see Strategy 1)
   d. **Community Dashboards and Community Scorecards:** CBOs test and implement Community Dashboards and Community Scorecard approach to support quality of care and social accountability for FP/RH. These will be specifically designed to support interventions promoting PPFP and will be linked to client assessments of quality of care.
   e. **Community Social Action:** Community action groups lead efforts to support compliance with existing and new Community mandates and health supporting norms.
   f. **Community Champions:** Adoption of senior local officials to chair, supervise and endorse CBO activities.

Gender Considerations

- Adopt a top-down approach for interventions focusing on changing social and gender norms, starting with building social approval through government approval and endorsement of activities by credible community influencers, particularly through clergy and religious scholars.
- Work in organized community groups to dismantle harmful gender norms and address through critical thought and reflection exercises. Invest early and meaningfully in community-led dialogue on power, rights, and responsibilities.
- Facilitate inclusion and representation of key audiences in all organized community groups. Include youth, as well men and women when forming or strengthening community groups.
- Identify and engage women-led CBOs, and women's community groups to enhance voice and inclusion of women in community platforms.

Strategy 3.2. Provider Behavior Change (PBC) for delivering high quality, person-centered, respectful care for supporting target FP/RH behaviors.

Audiences and Target Behaviors

PRIMARY AUDIENCE	HEALTHCARE PROVIDERS (HCPs)

AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
FACILITY-BASED HEALTHCARE PROVIDERS: DOCTOR, NURSE, LADY HEALTH VISITORS (LHVs), COMMUNITY MIDWIVES (CMWS)	• Provide high quality, person-centered, counselling and services for PPFP to women and couples during antenatal, natal, and post-natal care. • Provide high quality, person-centered, counselling for PAFP when delivering Post-abortion Care (PAC). • Deliver high quality, gender and youth sensitive respectful, person-centered FP/RH counseling, products, and services.
COMMUNITY-BASED HEALTHCARE PROVIDERS: LADY HEALTH WORKER (LHW), FAMILY WELFARE ASSISTANTS (FWA), COMMUNITY HEALTH WORKERS (CHWS)	• Provide high quality, person-centered, counselling and services for PPFP to women and couples during antenatal, and post-natal visits. • Provide high quality, person-centered, counselling and services for PAFP for women seeking and receiving Post-abortion Care (PAC). • Deliver high quality, gender and youth sensitive respectful, person-centered FP/RH counseling, products, and services.
ALLIED HEALTHCARE PROVIDERS: PHARMACISTS, RETAILERS	• Provide high quality, person-centered, counselling and family planning products, inclusive of PPFP and PAFP.
ALTERNATIVE HEALTHCARE PROVIDES HAKEEMS, HOMEOPATHS	• Provide correct information, counselling and referrals for family planning products and services, inclusive of PPFP and PAFP.

Communication & Engagement Objectives

i. **Create Descriptive Norm:** HCPs observe/perceive that other HCPs are providing high quality, gender and youth sensitive respectful, person-centered FP/RH counseling, products, and services.

ii. **Create Favorable Normative Mechanism:** to promote adoption of behavior through the following objectives:

   a. **Shift Injunctive norm:** HCPs believe that providing high quality, gender and youth sensitive respectful, person-centered FP/RH counseling, products, and services is expected of them socially, by their peers, supervisors, and by policy and regulatory provisions.
   b. **Improve Outcome:** HCPs believe that providing high quality, gender and youth sensitive respectful, person-centered FP/RH counseling, products, and services will lead to beneficial outcomes for their patients and clients, for the service provider professionally and socially, and for society at large.
   c. **Strengthen Group Identity:** Healthcare providers:
      - Have high aspirations for their professional and social identity.
      - Identify as supportive and socially responsible.
      - Develop shared values with role model service providers and professional role models providing high quality, gender and youth sensitive respectful, person-centered FP/RH counseling, products, and services.
      - Believe that their values require them to be gender and youth sensitive, person-centered, and respectful when providing counseling and/or services related to FP/RH.

Interventional Approach and Activities

The strategy recognizes that provider bias and behaviors are influenced by complex psycho-social factors. To address this, the PBC strategy views service providers as individuals within multifaceted environments that shape their actions and the quality of care they deliver. It extends beyond merely enhancing provider capacity or delivering value clarification and attitude transformation (VCAT) workshops and exercises. Provider behaviors are influenced a range of structural and systems factors and this comprehensive approach is aimed providing PWD, PS&H Department, development partners in the working group and other stakeholders with a roadmap offering a range of interventions operating at various levels, providing program teams with flexibility to tailor their approach according to specific needs and contexts.

1. POLICY LEVEL STRATEGIES

Given the innovative focus on male engagement as FP users, this approach will be essential for directly influencing the availability of services for women and men. PWD acknowledges that several policy initiatives exist and may be underway. This strategy identifies potential areas for policy advancement and highlights the importance of advocating for **revision of policies, advancing regulatory frameworks (**e.g., for task sharing), inclusion of minimum family planning standards, training curricula and materials, and modifying licensing and/or any accreditation requirements to integrate principles of high quality, gender and youth sensitive respectful, person-centered FP/RH counseling, products, and services.

2. INSTITUTIONAL APPROACHES AND STRATEGIES

At the institutional level this strategy recommends reviewing supply-side initiatives to also consider institutional aspects of service quality which can influence provider behaviors. These may include orientation of implementers, stakeholders, and providers in program networks to supportive policies, regulatory frameworks, minimum standards, and training curricula and materials requiring provision of respectful, person-centered care; reinforcing correct behaviors through Supportive Supervision and Mentoring systems that may be supported through development partners; and including financial and non-financial incentives, including rewards and recognition of in-network providers who deliver high quality, gender and youth sensitive respectful, person-centered FP/RH counseling, products, and services, including graduating providers to role models.

3. PROVIDER-FOCUSED STRATEGIES

There is a global dearth of low cost comprehensive PBC solutions that can be implemented at scale. This strategy recommends the adaptation and incremental adoption of the Beyond Bias PBC solution for Pakistan, **Nai Umang, focusing on promoting provision of PPFP and PAFP** counseling by service providers. The Nai Umang Solution has been rigorously tested for both public and private sector providers in Pakistan through a randomized controlled trial supported by the Bill and Melinda Gates Foundation (BMGF). A step-by-step How-To Guide is available to guide program adaptation for the strategy. It is anticipated that integration support for the Nai Umang solution will be at hand through donor supported investments that are already in place. A brief description is provided below.[40]

The ***Nai Umang* Solution** provides a clear set of activities for engaging, and supporting providers to deliver gender responsive, person-centered care and includes a validated client exist interview scale for informing provider report cards linked to non-financial rewards and recognition. The solution, overall, encompasses the following interventional approaches organized into **Summit**, **Connect**, and **Rewards** pillars. The approach is amenable for linking with the Hayat mobile application (developed by the Aga Khan Development Network) for supporting LHW and community health workes' service delivery quality. For more information, please refer to the Nai Umang How-To Guide.

i. Create and engage provider networks with a combination of in-person and virtual engagement.
ii. Hold provider VCAT workshops within networks to facilitate dialogue, discussion, and critical appraisal of outcomes of delivering biased care and services which overlook PPFP and PAFP, and vice-versa, among providers.
iii. Establish prevalence of respectful, person-centered PPFP care within provider networks by recognizing and showcasing peers and role models practicing principles of gender responsive person-centered care.
iv. Train and strengthen the capacity of providers to ensure correct knowledge and skills regarding PPAP and PAFP practices, procedures, and methods.
v. Provide user-friendly tools, guidelines, and cues-to-action for providers to reinforce and facilitate adoption of good practices and behaviors, e.g. provider tools (paper based or digital app-based) to facilitate correct PPFP and PAFP counseling.
vi. Share best practices and standards of care with in-person and virtual provider networks.
vii. Identify, recruit, train, mobilize, and showcase role models in provider networks using individual, community, and digital platforms to establish and reinforce respectful, person-centered values,

and practices related to PPFP and PAFP services, including FP services for men.

viii. Deploy Provider Report Cards informed by Client Quality Assessment feedback and acknowledge high performing providers routinely within networks through non-financial rewards.

ix. Thematically align IEC materials (digital messages, print media, facility and community level sign posting) shared through provider and stakeholder networks that use a combination of rational and emotional appeals to create dramatic relief and sensitize providers to negative outcomes of biased, disrespectful care.

4. COMMUNITY LEVEL APPROACHES AND STRATEGIES

i. Apply cross linkages across activities, PWD will collaborate with development partners to create linkages across strategies by undertaking community level approaches for PBC. These activities consist of engaging CPOL's, OBs, and societal influencers to publicly endorse, respectful, person-centered care, recognize service provider role models and encourage providers to deliver person-centered, respectful services for FP/RH.

ii. As described previously, this strategy recommends implementing community organization, social planning, and social action approaches linked to social accountability and client feedback mechanisms. PWD will steward partners to explore and operationalize proven approaches including community score cards or voice and accountability initiatives such as interface meetings among clients, community stakeholder/representatives, and local providers for reinforcement of community needs and expectations for providing respectful, person-centered, gender and youth sensitive PPFP and PAFP counseling. Please see Strategy 3.1 for additional details on these activities.

Gender Considerations

- Most service providers are women and as such are subject to the same social and gender norms that adversely affect other women in the community who they are serving. Special considerations must be given for how harmful gender norms affect service providers' wellbeing and their ability to deliver high-quality person-centered care. SBC initiatives should leverage providers networks and groups and encourage providers to share challenges affecting their ability to deliver and consider linking providers through small support groups.
- Gender bias and discrimination at the service delivery level can result in differences in quality and availability of services based on gender, age, disability, and other factors, limiting access to care for certain individuals or perpetuating harmful gender stereotypes. Strong value clarification aspects should be built into initial provider engagement approaches. Focusing on empathy for all as a driving theme can be useful when engaging service providers.
- Gender training for providers should emphasize the difference between personal values and professional standards of care. Special focus on building supportive norms for delivering person-centered counselling and respecting privacy and confidentiality of all individuals seeking care should be reinforced repeatedly.
- Even with health promoting values, providers may be hesitant to deliver certain services particularly to adolescents and youth due to fear of community reaction. SBC programs should pre-empt this risk and ensure that providers receive endorsement and support from community advocates and champions. The role or provider and community interface meetings (e.g., through community score cards described in Strategy 3.1) would be useful in addressing this barrier.

Strategy 3.3: Strengthened Stewardship of SBC efforts for improving service availability and utilization of target FP/RH services.

Audiences and Target Behaviors

PRIMARY AUDIENCE	DECISION MAKERS & DECISION INFLUENCERS (DMIs)

AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
PROVINCIAL OFFICE BEARERS PWD, DoH, PPHI, OTHER ASSOCIATED DEPARTMENTS	■ Participate in consultative prioritization, planning, and implementation of SBC strategies, interventions, and activities. ■ Prioritize SBC interventions in workplans and budgets for supporting availability and uptake of high quality, person-centered, gender sensitive FP/RH services.
DECISION MAKERS AND OFFICE BEARERS FROM DEVELOPMENT PARTNERS WORKING IN SBC FOR FP/RH	■ Participate in consultative prioritization, planning, and implementation of SBC strategies, interventions, and activities. ■ Prioritize SBC interventions in donor-funded project workplans and budgets for supporting availability and uptake of high quality, person-centered, gender sensitive FP/RH services.
DISTRICT OFFICE BEARERS UNDER PWD, DOH, AND ASSOCIATED LINE DEPARTMENTS	■ Develop and integrate SBC activities in district action plans. ■ Prioritize SBC interventions in workplans and budgets for supporting availability and uptake of high quality, person-centered, gender sensitive FP/RH services.

Stewardship Communication & Engagement Objectives

i. **Create Descriptive Norm:** DMIs observe/perceive that other DMIs actively participate in consultative prioritization, planning, and implementation of SBC strategies and prioritize SBC interventions for supporting for supporting availability and uptake of high quality, person-centered, gender sensitive FP/RH services.
ii. **Create Favorable Normative Mechanism:** to promote adoption of behavior through the following objectives:

   a. **Shift Injunctive Norm:** DMIs believe that participating in the consultative process and prioritizing SBC interventions for FP/RH services in workplans and budgets is expected of them socially, by their peers, supervisors, and by policy and regulatory provisions.
   b. **Improve Outcome Expectation:** DMIs believe that participating in the consultative process and prioritizing SBC interventions for FP/RH services in workplans and budgets will lead to beneficial outcomes for mothers and children, for families and their communities and for the legacy of their leadership.
   c. **Strengthen Group Identity:** Decision makers:

      - Have high aspirations for their professional and social identity.
      - Identify as supportive, progressive, and socially responsible.
      - Develop shared values with role model social advocates and senior leaders who participate in the consultative process and prioritize SBC interventions for FP/RH services in workplans and budgets.
      - Believe that their values require them to participate in the consultative process and prioritize SBC interventions for FP/RH services in workplans and budgets.

Interventional Approach and Activities

Engagement approaches under Strategy 3.3 are designed to support advocacy efforts and focus on specific behaviors related to endorsement of PWD stewarded key SBC messages, IEC content, community and HCP facing initiatives, and prioritizing value-based stewardship of workplans and budgets for supporting increased availability of high quality, gender and youth sensitive respectful, person-centered FP/RH counseling and services, for women and men. Intervention Approaches are conceptualized at Provincial and District levels.

1. STRATEGY FOR STRENGTHENING PROVINCIAL LEVEL SBC STEWARDSHIP FOR FP/RH

Activities at the provincial level are informed by the Informed by CCAT, operationalizing the stewardship theory of change presented in Figure 9. This process is designed to enable the Government of Punjab to engage with local actors and stakeholders in a cyclical and iterative five-phase process for SBC capacity strengthening and adaptive management. As stakeholders collaborate, learn and adapt at each phase of the cycle and through iterations of the cycle, SBC capacities and the quality of SBC efforts will improve overtime eventually leading to institutionalization of SBC programming. Key activities relate to each phase of this stewardship cycle.

PHASE 1: STRENGTHEN STEWARDSHIP FOR SBC FOR FP/RH:

In phase 1, the approach to implementation aims to leverage the role of PWD in strengthening stewardship for SBC in the province, foster stakeholder partnerships, and develop a comprehensive

activity roadmap. During phase 1 PWD will leverage technical assistance available through development partners to strengthen the nascent Family Planning SBC Working Group, with clearly specified terms of reference, structure and confirming stakeholder involvement through a consultative process guided by the PWD.

PHASE 2: ESTABLISH FUNDING AND FINANCING MECHANISMS FOR SBC FP/RH:

Phase 2 of the implementation cycle focuses on ensuring uninterrupted financing to sustain multi-level SBC approaches across Punjab. The approach emphasizes diversifying funding sources to reduce the burden of activities on the taxpayer, avoid dependence on single funding source, promoting synergy among stakeholders to maximize impact, and establishing continuous financial stewardship mechanisms. During this phase, PWD will steward with partners through dialogue in the working group to develop a costed implementation plan for priority activities described in the SBC Strategy and undertake a fiscal space analysis to identify funding and resource gaps and potential solutions for sustained financing through fiscal synergies among members of the working group focusing on SBC implementation. PWD will thus establish a multi-sectoral funding pool stewarded by the SBC Working Group, with budget-holding members and stakeholders directly leading and implementing activities outlined in the agreed upon costed implementation plan. Thus, the implementation approach aims to create a sustainable funding ecosystem, enhance collaboration among stakeholders, and ensure effective management of resources for impactful SBC mechanisms for promoting family planning across Punjab.

PHASE 3: CO-CREATE ACTIVITY DESIGNS, FP/RH CAMPAIGN, AND VALIDATION OF IEC MATERIALS:

Phase 3 of the implementation cycle is aimed at addressing the existing gaps in robust SBC and SBCC materials for implementing and disseminating across multiple levels and channels. During Phase 3 PWD will use the comprehensive activities described in this strategy document to convene Co-creation and prioritization session of the SBC Working Group. With technical assistance from development partners and the National SBC Community of Practice (CoP), PWD will facilitate stakeholders collaborate to agree on different activities and resource development needs, and craft a detailed activity plan, aligning efforts with overarching objectives and ensuring clear roles and responsibilities during the development, testing, validation, and approval stages for development of the FP SBC Resources for guiding the strategies described in the next section.

PHASE 4: STEWARD SBC STRATEGY IMPLEMENTATION & MONITOR PROGRESS:

Phase 4 of the implementation cycle encompasses direct implementation and incremental roll out of the different activities being led and supported by PWD and working group members and stakeholders. Through the platform of the SBC Working Group, PWD will facilitate dialogue between stakeholders including subsequent regular data reviews and adjustments conducted to maintain progress alignment, with quarterly progress review meetings serving as platforms for routine evaluation and adaptation.

PHASE 5: ESTABLISH EVALUATION MECHANISMS & SUGGEST COURSE CORRECTIONS:

Phase 5 of the implementation cycle underscores the importance of evidence and data-driven decision-making processes in guiding stewardship, financing, and SBC engagement efforts for family planning. Through formative assessments and rigorous evaluation mechanisms, implementation cycle aims to provide space for building into the system clear opportunities to address the current lack of evidence and documentation regarding drivers for SBC in family planning.

During this phase PWD will steward the SBC Working Group in applying the theories of change described in this strategy document and the provided indicators to develop robust mechanisms to evaluate the impact of different approaches in communities across Punjab. Towards this end, technical assistance from development partners and the National SBC CoP will be leveraged during the co-creation phase. By establishing a robust evidence base and evaluating the effectiveness of interventions, stakeholders can refine and optimize strategies to promote male involvement in family planning, ultimately contributing to healthier reproductive practices and informed decision-making among citizens of Punjab.

2. STRATEGIES FOR STRENGTHENING DISTRICT LEVEL STEWARDSHIP OF SBC FOR FP/RH

The approach recognizes the important role of social influencers and social advocates in swaying decision makers' opinion in favor or against key policy directions. The strategic approach will leverage the influence of these social advocates to endorse target behaviors being encouraged by the project SBC approach.

2.1. CREATE DESCRIPTIVE NORM FOR TARGET BEHAVIORS AMONG DECISION MAKERS AND INFLUENCERS (DMI)

Approach

- Community-led advocacy with policy makers and social influencers regarding international, and national standards, mandated, and recommendations for FP/RH service delivery and provincial commitments to technical and regulatory mandates.
- Use IEC in print and through digital communication channels to disseminate information, sensitize target audiences, and increase visibility of role models.

Activities

i. **Identification, engagement, and mobilization** of decision influencers as change agents, role models, and champions for key thematic areas at national, district, and community levels. This will link with the interventional approaches at community level.

ii. **CSO and CBO led capacity strengthening sessions** for change agents, policy makers, and social champions on the benefits of gender responsive FP/RH services, barriers to access, and key messages to promote effective stewardship of priority health areas through affirmative policy and implementation decisions supporting FP/RH service utilization by individuals and families in target communities.

iii. **CSO and CBO led value clarification sessions** for change agents, policy makers, social champions, and other public sector officials in districts.

iv. **Community Katchehry** to establish social prevalence among peers of prioritized stewardship for gender and youth sensitive respectful, person-centered FP/RH services by recognizing, showcasing, and celebrating peers delivering affirmative stewardship of these health areas.

v. **Identify and involve decision influencers** as advocates and role models and disseminate testimonials and statements for engaging decision makers.

vi. **Radio and local cable TV spots** with testimonials from social advocates, influencers, role model decision makers. Links and crosses over with individual and interpersonal level strategy.

vii. **Radio and TV Talk shows** on pre-approved topics with social advocates and decision makers. Links to and crosses over with individual and interpersonal strategies.

2.2. CREATE FAVORABLE NORMATIVE MECHANISM TO PROMOTE ADOPTION OF TARGET BEHAVIORS.

Approach

- Strengthen public-private and community dialogue platforms for supporting advocacy efforts.
- Support community inclusion and voice in dialogue for advocacy to improve FP/RH care, and link to social accountability approaches.
- Improve salience, knowledge and awareness regarding policy and regulatory quality mandates for FP/RH care.
- Advocacy for the provision of financial resources to improve service readiness, delivery, and quality of care.
- Advocacy for the provision of financial resources to align conflicting policies, print and disseminate health policy.
- Create salience of community need and priorities related to priority health areas for social advocates, champions, decision makers.

Activities

i. **Community-led dialogue** with social advocates and decision-makers on FP/RH, needs, constraints, and priority solutions across a range of potential activities: Town Hall meetings, Facility and Site visits, Community-led events and forums, District Health Meetings, Social accountability, and Community-score card Interface meetings.

ii. **Periodic reviews** of existing health policies, with a focus on gender responsiveness, considering new developments and monitor health policy implementation.

iii. **Community-led co-design workshops** with public and private sector stakeholders across sectors to identify priority needs, leverage synergies, and build capacity for effective health stewardship in districts. These may include identifying and prioritizing health system strengthening solutions related to improving access to quality health care, including for example:

- Strengthening information systems and capacity.
- Strengthening continuous quality improvement mechanisms.
- Implementing Supportive Supervision and Mentorship mechanisms.
- Leveraging technology solutions to build service provider capacity.
- Digitizing information management systems.
- Formative assessment and research on thematic area needs and resources.

Several ongoing initiatives spearheaded by development partners and through donor investments may be leveraged to support this.

iv. **Social media and WhatsApp networks:** Thematically aligned IEC content which use a combination of rational and emotional appeals to create dramatic relief and sensitize decision makers to negative outcomes of poor quality, disrespectful health care and services.

v. **Mass media:** Radio and TV spots with testimonials from social advocates, influencers, role model decision makers. Radio Talk shows pre-approved topics with social advocates and decision makers. IEC content adapted for relevant medium as described earlier.

Gender Considerations

- Institutional-level gender bias and discrimination may exist within health care facilities or systems. This can result in gender-based differences in quality and availability of services, leading to disparities in access to care. Undertaking rigorous values clarification and gender sensitization at institutional level is essential. Such initiatives should ideally be led by community groups and local stakeholders directly with the implementer (e.g. PWD, development partners) facilitating this.
- Institutional power dynamics and gender-based occupational segregation may impact access to priority FP/RH services. Decision-making power may be concentrated among male providers or leaders, leading to limited input or influence from women. Approaches should ensure that their strategies are inclusive and wherever possible women led.
- Lack of gender-sensitive policies and guidelines, gender responsive programming, gender blind-financing and governance, and gender diversity among health care providers may affect quality and access to services. Existing gender policies should be reviewed and updated as a key area of focus when developing intervention plans.

Preliminary Implementation Plan

The Implementation plan accompanying this strategy focuses on essential activities over the next one year that will serve to lay the foundation for robust implementation of theory-informed, community-led, and consultatively stewarded SBC activities for FP/RH. This Action Plan presented in Annex 2, has been compiled as a comprehensive implementation planning tool designed to facilitate consultative operational planning and better-informed costing for longer term action planning over the next four years. Currently, a preliminary implementation plan is summarized below for the initial phases of the strategy implementation, and consolidated budget estimation for SBCC initiatives by strategy is presented in Annex 2 and 3, and by channel and medium is presented in Annex 3.

PWD in collaboration with IRMNCH and the PFPP will lead the implementation of the strategy, facilitating three complementary and concurrent implementation workstreams designed to gradually coalesce over the next nine months to one year ensuring that current fragmentation across SBC investments in Punjab is effectively addressed. The concurrent implementation workstreams include the following.

1. Supporting existing investments to build the momentum of ongoing SBCC activities
2. Strengthen collaboration and synergies for SBC across public and private sector stakeholders
3. Co-design, develop, and roll-out priority SBC interventions

IMPLEMENTATION WORKSTREAM 1
SUPPORTING EXISTING INVESTMENTS AND BUILD THE MOMENTUM OF ONGOING SBCC ACTIVITIES

PWD will leverage its substantial portfolio of immediately available and ready communication materials to continue salience building of family planning by focusing strategic dissemination of IEC content through Mass Media channels, including television, print, and radio. Content will also be circulated through current social media channels. In addition to reaching citizens with these critical messages to build social momentum.

This early and rapid roll out will also serve to garner attention from stakeholders and mobilize partners and donors for supporting the strategy operationalization process described below. These priority activities earmarked for early rollout are included in the SBC Strategy with implementation timelines and preliminary estimated costs. These will be led directly by PWD and are only enumerated below for reference.

CONTINUATION OF ONGOING SBCC ACTIVITIES

Mid-Media Activities

- University partnerships for Youth FP Awareness Sessions and Sporting Events
- Youth HUB Centers at Major Universities
- Learning Sessions with Academia
- Pre-marital – Sessions at Provincial and district level
- Learning Sessions with Journalist
- Special and International day Celebrations
- Door to door campaign
- PWD FP Road Show
- Seminar and Conferences with Community Champions – Provincial and district level
- Ulema engagement – Provincial and district level

Mass Media Campaign

- Television 1: Talk shows
- Television 2: Drama serial
- Print Media 1: Newspaper Public Service Messaging and Supplements
- Radio 1: Radio Spots and Talk Shows

Social Media Campaign

- YouTube videos and public service messages
- Facebook, Twitter, and Instagram posts
- TikTok reels from above resources

IMPLEMENTATION WORKSTREAM 2
STRENGTHEN COLLABORATION AND SYNERGIES ACROSS PUBLIC AND PRIVATE SECTOR STAKEHOLDERS

Activities under this workstream are described under Strategy 3.3 and are designed to enable the PWD to engage stakeholders in a cyclical and iterative five-phase process for SBC capacity strengthening and adaptive management. As stakeholders collaborate, learn and adapt at each phase of the cycle and through iterations of the cycle, SBC capacities and the quality of SBC efforts will improve overtime eventually leading to institutionalization of SBC programming. Immediate next steps pertain operationalization of the strategy through a consultative and inclusive process between Sept and Dec 2024. Pertaining to the first two phases of the cycle, these activities are described in detail with associated timelines in the strategy document and are summarized below with tentative dates of completion.

S/No	Milestone	Preliminary Timeline for Completion
1	SBC Working Group Terms of Reference, Membership, Role and Responsibilities, and schedule of stewardship activities finalized.	30 December 2024
2	Stakeholder Coworking and Consultation Workshop for SBC strategy review, validation, and cocreation of Implementation Plans for priority interventions for SBC in Punjab.	30 December 2024
3	Detailed Implementation Plan for SBC finalized.	30 November 2024
4	Costed Implementation Plan for SBC in Punjab developed.	30 November 2024
5	Fiscal Space Analysis undertaken for identifying funding gaps and financing solutions, including contributions for supporting activities.	15 December 2024
6	Stakeholder Coworking and Consultation Workshop for validation of SBC Costed Implementation Plan and pool of funded SBC Activities in Punjab.	30 December 2024
7	Launch of the Punjab SBC Costed Implementation Plan.	15 January 2025

IMPLEMENTATION WORKSTREAM 3
CO-DESIGN, DEVELOP, AND ROLL-OUT PRIORITY SBC INTERVENTIONS

PWD, with support from development partners, will lead focused activities aimed at building a strong foundation for existing and new SBC initiatives and developing new priority interventions focusing on PPFP and PAFP.

1. **Activities to address technical and foundation gaps in SBC for FP/RH:** Under this work stream PWD will lead the development and validation of foundational SBC elements including key messages for a wide range of target audiences, campaign branding and marking plan for SBC initiatives under the Punjab Family Planning Program, and development of priority IEC materials for a range of channels, as well as a common set of metrics and indicators for success. Work on this will begin in Jan 2025 and will continue through the year.

2. **Design, Development, and Implementation of Priority SBC interventions with a focus on PPFP and PAFP:** Under this workstream PWD will prioritize the design, development and operationalization of priority SBC interventions for the Punjab Family Planning Program. These include Intervention Design and Manual for the following priority interventions:

   i. Provider Behavior Change (PBC) focusing on increasing the provision of PPFP/PAFP counseling during maternal and child health encounters in public and private sectors.
   ii. Lay Health Worker-led (LHWs, CHWs, FWA's FWW's, others) IPC for PPFP, with participatory engagement approaches and tools for IPC in household and group settings.
   iii. Community Engagement for community-led social action, including roles and responsibilities for Youth-led Organizations, Community Volunteers, Champions and Ambassadors.
   iv. Social Marketing, Voucher schemes for BISP Beneficiaries, and Clinical Fractional Franchising for FP, linked to health worker-led IPC for PPFP/PAFP.

While preliminary work on all the above activities has already been initiated, it is anticipated that the milestones described above will be completed over a three-to-six-month period following the confirmation of the implementation plan in October 2025. A tentative implementation plan is presented below.

S/No	Milestone	Preliminary Timeline for Completion
1	Development and validation of key messages for a wide range of target audiences	30 December 2024 & 31 March 2025
2	Development and validation of campaign branding and marking plan for SBC initiatives under the Punjab Family Planning Program	30 December 2024
3	Development and validation of priority IEC materials for a range of channels and audiences	31 March 2025
4	PPFP/PAFP Intervention Design and Manual for Provider Behavior Change (PBC)	31 March 2025
5	PPFP/PAFP Intervention Design and Manual for Lady Health Workers	31 March 2025
6	Intervention Design and Manual for Community Engagement and Community-led Social Action for PPFP/PAFP	31 March 2025
7	Intervention Design and Manual for Social Marketing, Voucher schemes for BISP Beneficiaries, and Clinical Fractional Franchising for FP, linked to health worker-led IPC	30 December 2024

Section 4

Preliminary Monitoring, Evaluation, and Learning (MEL) Plan

Plan for Monitoring

This monitoring plan guides the assessment of progress toward key objectives of the SBC Strategy. It will determine whether expected actions have been completed in comparison to the specified indications. This will require continuous data collection for ongoing learning about program quality, reach, and initial outcomes. The learning questions are as follows:

1. What is the reach and engagement level of the SBC strategy for FP/RH across different levels of influence?
2. How many activities have been conducted and how many stakeholders have been exposed to SBC strategies for FP?
3. What is the level of engagement for community influencers in implementing community engagement activities that promote the target behaviors for varied target audiences described above?

Table 15: Key Indicators and Sources of data for SBC Strategy Evaluation

	WHAT	WHERE	HOW	WHEN	WHO
S/No	*Indicator*	*Source of Data*	*Data Collection Tool*	*Frequency of Data Collection*	*Focal Partner*
Individual Level					
1.1	Community-based workers oriented/trained in conducting SBC interventions	Activity report	Participant registration forms & attendance list	Quarterly	TBD
1.2	# Home visits conducted	Activity reports	CHW register	Quarterly	TBD
1.3	# Community dialogues or events conducted	Activity reports	Activity forms	Monthly	TBD
1.4	# Radio outputs (spot ad, mentions, talk shows) aired	Activity report	Registration & payment forms for panelists, CD recording logs	Monthly	TBD
1.5	# IEC materials distributed & disseminated	Activity report	CBO IEC distribution Form	Quarterly	TBD
1.6	# People reached with interventions	Community survey	Community survey tool	Annual	TBD
1.7	# People reached with digital health approaches	Community survey	Community survey tool	Annual	TBD

S/No	WHAT *Indicator*	WHERE *Source of Data*	HOW *Data Collection Tool*	WHEN *Frequency of Data Collection*	WHO *Focal Partner*
Individual Level					
1.8	# Referrals by community-based workers	Activity report	CHW register, referral slips, health facility registration	Monthly	TBD
Household level					
2.1	# Men (and/or household influencers) oriented/trained in community engagement activities	Activity reports	Participant registration forms, attendance list	Quarterly	TBD
2.2	# Men (and/or household influencers) participating/conducting community engagement activities	Activity reports	Participant registration forms, attendance list	Quarterly	TBD
Community level					
3.1	# Community influencers oriented/trained in community engagement activities	Activity reports	Participant registration forms, attendance list	Quarterly	TBD
3.2	# Community groups oriented/trained	Activity reports	Participant registration forms, attendance list	Quarterly	TBD
3.3	# Community groups participating/conducting community engagement activities	Activity reports	Participant registration forms, attendance list	Quarterly	TBD
Facility / Provider Level					
4.1	# Facility health workers reached with PBC interventions	Activity reports	Participant registration forms, attendance list	Quarterly	TBD
4.2	# Health facilities implementing PBC strategies	Activity reports	Facility registers	Quarterly	TBD
Institutional & Policy Level					
5.1	# district officials and community members oriented in SBC activities	Activity reports	Participants registration forms, attendance list	Quarterly	TBD
5.2	# DHT members participating in SBC and engagement activities	Activity reports	Participants registration forms, attendance list	Quarterly	TBD

Plan for Evaluation

The SBC Strategy can be evaluated for effectiveness, relevance, and success of SBC strategy objectively and methodically in relation to desired outcomes, with emphasis on determining the level of attribution by attempting to link observed outcomes to SBC interventions. The evaluation plan will facilitate determination of whether the SBC and community engagement activities are achieving the desired impact.

A longitudinal **study design** with comparison and intervention arms with a baseline and endline evaluation is recommended to measure the immediate and intermediate outcomes. Long-term health outcomes are beyond the scope of this evaluation. The **learning questions** are as follows:

1. What impact did the community engagement interventions have on FP/RH service uptake?
2. What are the changes in individuals' knowledge, attitude, perceptions of norms, personal agency, and intention after the implementation of SBC and community engagement activities?
3. What impact did the interventional approaches have on social and gender norms or power dynamics within the community with respect to gender and youth responsive, FP/RH service availability and uptake?
4. What is the level of engagement for community influencers in implementing community engagement activities that promote target FP/RH?
5. How did the interventions improve provider behaviors related to provision of high quality, gender, and youth responsive, person-centered, respectful FP/RH counseling, products, and services?
6. What impact did the strategy have on the behaviors of decision makers in stewarding gender and youth responsive, person-centered FP/RH services?

Table 16: Key Indicators and Sources of data for SBC Strategy Evaluation

S/No	WHAT *Indicator*	WHERE Source *of Data*	HOW *Data Collection Tool*	WHEN *Frequency of Data Collection*	WHO *Focal Partner*
Individual Level					
Immediate (Psychosocial outcomes)					
1.1	% Women reporting intention to use/continue using FP/RH services	Community survey report	Community survey	Baseline & endline	SBC Partner
1.2	% Women reporting intention to Adopt target behaviors	Community survey report	Community survey	Baseline & endline	SBC Partner
1.3	% Women reporting favorable attitude towards target behaviors	Community survey report	Community survey	Baseline & endline	SBC Partner
1.4	% Women reporting high self-efficacy/agency for adopting target behaviors	Community survey report	Community survey	Baseline & endline	SBC Partner
1.5	% Women reporting favorable perceived norms for adoption of target behaviors	Community survey report	Community survey	Baseline & endline	SBC Partner
1.6	% Women with correct knowledge of and skilled care sources	Community survey report	Community survey	Baseline & endline	SBC Partner
Intermediate (Behavioral outcomes)					
1.7	% Women exposed to full package of intervention who redeem a referral slip for accessing services at a facility	Community survey	Community survey tool	Baseline & endline	SBC Partner
1.8	% Women exposed to full package of intervention who report adopting target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner
1.9	% Women exposed to full package of intervention who report continued adoption of target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner
Household Level					
2.1	% Men who report favorable descriptive norms for ISC	Community survey	Community survey tool	Baseline & endline	SBC Partner
2.2	% Men who report favorable injunctive norms for ISC	Community survey	Community survey tool	Baseline & endline	SBC Partner
2.3	% Men who report favorable outcome expectations for ISC	Community survey	Community survey tool	Baseline & endline	SBC Partner
2.4	% Men who report favorable descriptive norms for adoption of target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner
2.5	% Men who report favorable injunctive norms for adoption of target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner
2.6	% Men who that report favorable outcome expectations for adoption of target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner

Community Level					
3.1	% Community influencers participating/conducting community engagement activities	Activity reports	Attendance list, participant registration forms	Quarterly	CBO
3.2	% Members of community groups participating/conducting community engagement activities who report high self-efficacy for supporting efforts to address challenges related to women's health, adoption of target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner
3.3	% Community influencers who report favorable descriptive norms for ISC	Community survey	Community survey tool	Baseline & endline	SBC Partner
3.4	% Community influencers who report favorable injunctive norms for ISC	Community survey	Community survey tool	Baseline & endline	SBC Partner
3.5	% Community influencers who report favorable outcome expectations for ISC	Community survey	Community survey tool	Baseline & endline	SBC Partner
3.6	% Community influencers who report favorable descriptive norms for adoption of target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner
3.7	% Community influencers who report favorable injunctive norms for adoption of target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner
3.8	% Community influencers who report favorable outcome expectations for adoption of target behaviors	Community survey	Community survey tool	Baseline & endline	SBC Partner
Facility & Provider Level					
4.1	% Facility health workers trained through PBC interventions	Facility health workers survey	Facility health workers survey instrument	Baseline & endline	SBC Partner
4.2	% Health facilities implementing PBC strategy	Facility health workers survey	Facility health workers survey instrument	Baseline & endline	SBC Partner
4.3	% Facility health workers who report favorable descriptive norms for providing gender responsive FP/RH and other services	Facility health workers survey	Facility health workers survey instrument	Baseline & endline	SBC Partner
4.4	% Facility health workers who report favorable injunctive norms for providing gender responsive FP/RH and other services	Facility health workers survey	Facility health workers survey instrument	Baseline & endline	SBC Partner
4.5	% Facility health workers who report favorable outcome expectations for providing gender responsive FP/RH and other services	Facility health workers survey	Facility health workers survey instrument	Baseline & endline	SBC Partner

4.6	% Facility health care workers who receive a score of >85% for person centeredness of care by clients	Client Exit survey report	Nai Umang Scale for Measuring Perceived Person Centeredness of Care28	Baseline & endline	SBC Partner
Institutional & Policy Level					
5.1	% district decision makers and social influencers that report favorable descriptive norms for prioritizing stewardship of Gender responsive FP/RH and other services	Stakeholder survey	Stakeholder survey tool	Baseline & endline	SBC Partner
5.2	% district decision makers and social influencers that report favorable injunctive norms for prioritizing stewardship of Gender responsive FP/RH and other services	Stakeholder survey	Stakeholder survey tool	Baseline & endline	SBC Partner
5.3	% district decision makers and social influencers that report favorable outcome expectations for prioritizing stewardship of Gender responsive FP/RH and other services	Stakeholder survey	Stakeholder survey tool	Baseline & endline	SBC Partner

References


چیف خاندان
خوشحال پاکستان
فیملی ویلفیئر اسسٹنٹ
محکمہ بہبود آبادی، حکومت پنجاب

1. Porter, C. M. (2016). Revisiting Precede–Proceed: A leading model for ecological and ethical health promotion. Health Education Journal, 75(6), 753–764. Available from: https://-doi.org/10.1177/0017896915619645
2. 7th Population and Housing Census, 2023. Pakistan Bureau of Statistics, Government of Pakistan. Available from: https://www.pbs.gov.pk/content/announcement-results-7th-population-and-housing-census-2023-digital-census
3. UNFPA Division for Communications and Strategic Partnerships (2023). State of World Population Report 2023; United Nations Population Fund. Available from: https://www.unfpa.org/sites/default/files/swop23/SWOP2023-ENGLISH-230329-web.pdf
4. UNFPA, 2023. State of World Population Report provides infinite possibilities for Pakistan. Available from: https://pakistan.unfpa.org/en/news/state-world-population-report-provides-infinite-possibilities-pakistan
5. National Institute of Population Studies (NIPS) and ICF. 2018. Pakistan Demographic and Health Survey 2017-18. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF. Available from: https://pwd.punjab.gov.pk/system/files/key%20indicator%20PDSH.pdf
6. Socio-economic Indicators of Punjab at district level, 2023. Pakistan Bureau of Statistics, Islamabad. Available from: https://www.pbs.gov.pk/publication/socio-economic-indicators-punjab-district-level
7. Punjab Health Profile, 2024. Specialized Healthcare and Medical Education Department, Government of Punjab. Available from: https://health.punjab.gov.pk/PunjabHealthProfile.aspx
8. World Bank Group (n.d.). World Bank Databank on Health Nutrition and Population Statistics-Pakistan. Retrieved 10 May 2024 from: https://data.worldbank.org/country/pakistan
9. Bureau of Statistics (2018) Multiple Indicator Cluster Survey (MICS), 2017-2018. Planning and Development Board, Government of the Punjab. Available from: https://www.unicef.org/pakistan/media/3121/file/Multiple%20Indicator%20Cluster%20Survey%202017-18%20-%20Punjab.pdf
10. World Health Organization. (2013). Programming strategies for postpartum family planning. Available from: https://iris.who.int/bitstream/handle/10665/93680/9789241506496_eng.pdf?sequence=1
11. Gul, X., Hameed, W., Hussain, S., Sheikh, I., & Siddiqui, J. (2019). A study protocol for an mHealth, multi-centre randomized control trial to promote use of postpartum contraception amongst rural women in Punjab, Pakistan. BMC Pregnancy and Childbirth, 19(1). Available from: https://doi.org/10.1186/s12884-019-2427-z
12. Cavallaro, F. L., Benova, L., Owolabi, O. O., & Ali, M. (2019). A systematic review of the effectiveness of counselling strategies for modern contraceptive methods: what works and what doesn't? BMJ Sexual & Reproductive Health, 46(4), 254–269. Available from: https://-doi.org/10.1136/bmjsrh-2019-200377
13. Ismail, A., Ashraf, M., Idris, I. B., Thaver, I., Ahmad, A. M., & Siddique, S. J. (2021). Identifying factors associated with the use of a scaled-up postpartum family planning project implemented in Punjab, Pakistan. Malaysian Journal of Public Health Medicine, 21(2), 466–474. Available from: https://doi.org/10.37268/mjphm/vol.21/no.2/art.1091
14. High Impact Practices in Family Planning (HIPs) (2022). Immediate postpartum family planning: a key component of childbirth care. Washington, DC: HIP Partnership; May, 2022 Retrieved from: https://www.fphighimpactpractices.org/briefs/immediate-postpartum- family-planning/
15. Sathar, Z., Singh, S., Rashida, G., Shah, Z., & Niazi, R. (2014). Induced abortions and unintended pregnancies in Pakistan. Studies in family planning, 45(4), 471-491. Retrieved from: https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1728-4465.2014.00004.x

16. Arshad, A., Aziz, H., Shabbir, G., Shakya, S., & Munir, Z. (2023). Improving safe post-abortion care practices: A study on interventions implemented by Ipas Pakistan. Frontiers in Public Health, 11. Available from: https://doi.org/10.3389/fpubh.2023.1004381
17. Fleming, P. J., Silverman, J., Ghule, M., Ritter, J., Battala, M., Velhal, G., Nair, S., Dasgupta, A., Donta, B., Saggurti, N., & Raj, A. (2018). Can a Gender Equity and Family Planning Intervention for Men Change Their Gender Ideology? Results from the CHARM Intervention in Rural India. Studies in Family Planning, 49(1), 41–56. Available from: https://doi.org/10.1111/sifp.12047
18. Kamran, I., Tasneem, Z., Parveen, T., & Niazi, R. M. (2015). Family planning through the lens of men: Readiness, preferences, and challenges. Knowledge Commons. Available from: https://-knowledgecommons.popcouncil.org/departments_sbsr-rh/878/
19. Kamran, I., Khan, M., Tasneem, Z. (2013). Involving men in reproductive and fertility issues: Insights from Punjab. Population Council. Available from: https://openknowledge.world-bank.org/entities/publication/2409eb71-953d-5e44-bec6-1d6b3bc83fcb
20. Gul, A. X. (2021). Application of the Integrated Behavior Model to Explain and Promote Uptake of Modern Family Planning Methods among Married Women of Reproductive Age in Rural Areas of Punjab, Pakistan: The IRADA Project (Publication No. 28714933). [Doctoral Dissertation, The George Washington University] ProQuest Dissertations & Theses. Available from: https://www.proquest.com/open-view/0659fdd31ab5af1d0fe4206f02c794ed/1?pq-origsite=gscholar&cbl=18750&diss=y
21. McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. Health education quarterly, 15(4), 351-377. Available from: https://scottbarrykaufman.com/wp-content/uploads/2019/07/Eco-logicalPerspective-McLeroy.pdf
22. Kasprzyk, D., Montaño, D. E., & Fishbein, M. (1998). Application of an integrated behavioral model to predict condom use: A prospective study among high HIV risk Groups1. Journal of Applied Social Psychology, 28(17), 1557-1583. Available from: https://www.researchgate.net/-profile/Daniel-Montano-2/publica-tion/229700664_Application_of_an_Integrated_Behavioral_Model_to_Predict_Condom_Use_A_Prospective_Study_Among_High_HIV_Risk_Groups1/links/5b51da0645851507a7b30a79/Application-of-an-Integrated-Behavioral-Model-to-Predict-Condom-Use-A-Prospective-Study-Among-High-HIV-Risk-Groups1.pdf
23. Fishbein, M. (2000). The role of theory in HIV prevention. AIDS Care, 12(3), 273–278. Available from: https://doi.org/10.1080/09540120050042918
24. Montano, D., & Kasprzyk, D. (2008). Theory of reasoned action, theory of planned behavior and the integrated behavior model. In K. Glanz, B. K. Rimer & K. Viswanath (Eds.), Health behavior and health education: Theory, research, and practice (4th ed., pp. 67-96). San Francisco, CA: John Wiley & Sons.
25. Rimal, R. N., & Real, K. (2005). How Behaviors are Influenced by Perceived Norms. Communication Research, 32(3), 389–414. Available from: https://-doi.org/10.1177/0093650205275385
26. Rimal, R. N., Lapinski, M. K., Cook, R. J., & Real, K. (2005). Moving toward a theory of normative influences: how perceived benefits and similarity moderate the impact of descriptive norms on behaviors. Journal of Health Communication, 10(5), 433–450. Available from: https://-doi.org/10.1080/10810730591009880
27. Rimal, R. N. (2008). Modeling the relationship between descriptive norms and behaviors: a test and extension of the Theory of Normative Social Behavior (TNSB) . Health Communication, 23(2), 103–116. Available from: https://doi.org/10.1080/10410230801967791

28. Rothman, J. (1995). Approaches to community intervention. Strategies of community intervention, 5, 26-63.
29. Wallerstein, N., & Bernstein, E. (1988). Empowerment Education: Freire's ideas adapted to health education. Health Education Quarterly, 15(4), 379–394. Available from: https://-doi.org/10.1177/109019818801500402
30. Minkler, M., & Wallerstein, N. (2019). 3. Improving Health through Community Organization and Community Building: Perspectives from Health Education and Social Work. In Rutgers University Press eBooks (pp. 37–58). Available from: https://-doi.org/10.36019/9780813553146-005
31. Kegler, M. C., & Swan, D. W. (2012). Advancing coalition theory: the effect of coalition factors on community capacity mediated by member engagement. Health education research, 27(4), 572-584. Available from: https://academic.oup.com/her/article-abstract/27/4/572/589530
32. Chouinard, J., Tovey, T. L., & Kidd, K. (2023). The Evaluation of Equity-Focused Community Coalitions: A Review of the Empirical Literature. Journal of Multi-Disciplinary Evaluation, 19(45), 50-66. Available from: https://journals.sfu.ca/jmde/index.php/jmde_1/article/download/743/743/4699
33. Haque, A. (2004). Psychology from Islamic Perspective: Contributions of Early Muslim Scholars and Challenges to Contemporary Muslim Psychologists. Journal of Religion and Health, 43(4), 357–377. Available from: https://doi.org/10.1007/s10943-004-4302-z
34. Kegler, M. C., & Swan, D. W. (2011). Advancing coalition theory: the effect of coalition factors on community capacity mediated by member engagement. Health Education Research, 27(4), 572–584. Available from: https://doi.org/10.1093/her/cyr083
35. Chouinard, J., Tovey, T. L., & Kidd, K. (2023). The Evaluation of Equity-Focused Community Coalitions: A Review of the Empirical Literature. Journal of MultiDisciplinary Evaluation, 19(45), 50-66. Available from: https://journals.sfu.ca/jmde/index.php/jmde_1/article/download/743/743/4699.
36. Veillard, J. H. M., Brown, A. D., Barış, E., Permanand, G., & Klazinga, N. S. (2011). Health system stewardship of National Health Ministries in the WHO European region: Concepts, functions and assessment framework. Health Policy, 103(2–3), 191–199. Available from: https://-doi.org/10.1016/j.healthpol.2011.09.002
37, Edward, U. A., Okoro, L. A., & Orim, E. G. (2014). Exploring the Potentials of Community Theatre as a Tool for Social Change: The Participatory Communication Method. Available from: https://philpapers.org/rec/ADIETP
38. Boddam-Whetham, L., Gul, X., Al-Kobati, E., & Gorter, A. C. (2016). Vouchers in fragile states: reducing barriers to long-acting reversible contraception in Yemen and Pakistan. Global Health: Science and Practice, 4(Supplement 2), S94-S108. Available from: https://www.ghsp-journal.org/content/4/Supplement_2/S94.-full?__hstc=175320440.99a265337744294b740e0787aea508c4.1576713600072.1576713600073.1576713600074.1&__hssc=175320440.1.1576713600075&__hsfp=3969827736
39. Broughton, E. I., Hameed, W., Gul, X., Sarfraz, S., Baig, I. Y., & Villanueva, M. (2017). Cost-effectiveness of a family planning voucher program in Rural Pakistan. Frontiers in Public Health, 5, 227. Available from: https://www.frontiersin.org/articles/10.3389/fpubh.2017.00227/pdf
40. Beyond Bias Practical 'How-to Guide': Adapting and Implementing the Beyond Bias Model: Solutions to Reduce Provider Bias in Contraceptive Service" (Watertown, MA, USA: Pathfinder International, 2022. Available from: https://www.pathfinder.org/wp-content/uploads/2022/12/PF-069-Beyond-Bias-How-to-Guide_EN_r11.pdf

Annexures


متوازن خاندان
خوشحال پاکستان
POPULATION WELFARE DEPARTMENT

Annex 1: Strategy Development Process and Stakeholders Consulted

Date	Output	Methods	Stakeholders Consulted
22 Jun 2023	• Rapid Landscape Assessment of Existing Health System and Key System Strengthening Partners for SBCC for PPFP and PPFP	• Key Informant Interviews • Desk Review • Review of Records	**Punjab Government** • Ms. Saman Rai, Director General PWD Punjab • Dr Mohammad Ilyas Gondal, Director General Health Services, P&SHD, Punjab • Dr Khalil Ahmed, Program Director, IRMNCH & Nutrition Program, Punjab • Dr Zubda Riaz Director Technical PWD Punjab • Ms. Hina Riaz Assistant Director Communication PWD Punjab **Development Partners** • Dr Jamil Ahmad - Program Specialist SRH, UNFPA, Pakistan • Mr. Jonathan Shadid - Chief of SBC, UNICEF, Pakistan • Dr Shabbir Awan - Country Director, Ipas, Pakistan • Dr Fauzia Asad - Country Director, Jhpiego, Pakistan • Dr Khurram Azmat - Director Technical Services, MSS • Dr Azra Ahsan - President, National Committee for Maternal and Neonatal Health • Dr Saadiah Pal - Member, National Committee for Maternal and Neonatal Health • Mr. Fawad Shamim - General Manager programs, Regulatory Affairs and NBD, Greenstar Social Marketing • Dr Sana Durvesh - Social Franchise Manager • Dr Anjum Akhtar - Director Program Management Division, Rahnuma-FPAP • Mr. Sarfraz Kazmi - Consultant, UNFPA, Punjab • Mr. Afzal Hussain - General Manager & Chief Strategy Officer, M&C SAATCHI, Pakistan • Dr Rubina Suhail - Consultant Gynecologist, Hameed Latif Hospital, Lahore • Dr. Xaher Gul – Sr. Global Advisor for SBC and Health Markets, Pathfinder International

Date	Output	Methods	Stakeholders Consulted
20 Mar 2024	• Scope of work and technical assistance needs for preparation of Social Behavior Change (SBC) Strategy for the Punjab Family Planning Program. • Engagement of relevant departments and stakeholders. • Decision on scope, timelines and next steps.	• Consultative Meeting of TWG for PFPP DLI 4.1.	Stakeholders Consulted • Dr. Zubda Riaz, Director Technical PWD • Mr. Qudrat ullah, Director General PR • Mr. Hassan Iqbal Dogar, Asst DG, PWD • Mr. M. Afzal Chauhdhry, Dy. Director IEC, PWD • Mr. Kaleem ud din, Section Officer, Higher Education Department • Mr. Basit Tahir, Secondary Education Department • Ms. Maria Javaid, Section Officer, Women Development Department • Ms. Amna Aksheed, General Manager Grants, PPIF • Ms. Shamazat Babar, Grants Associate • Mr. Mansoor Riaz, Provincial Lead Punjab, Pathfinder International
2 Apr 2024	• 1st Draft of the SBC Strategy for FP/MNCH Punjab including Key Gaps and Challenges to address; technical approach and framework	• Desk review of existing data on key health behaviors • Desk review for published evidence on behavioral drivers for priority behaviors • Draft 1 was presented to TWG for PFPP DLI 4.1. • Feedback and consultation for alignment and next steps	Stakeholders Consulted • Dr. Zubda Riaz, Director Technical PWD • Mr. Qudrat ullah, Director General PR • Mr. Hassan Iqbal Dogar, Asst DG, PWD • Mr. M. Afzal Chauhdhry, Dy. Director IEC, PWD • Ms. Bushra Naveed, Add. Director Monitoring & Evaluation, PWD • Dr. Fawad Ahmed, Manager Nutrition, IRMNCH & NP • Mr. Kaleem ud din, Section Officer, Higher Education Department • Mr. Basit Tahir, Secondary Education Department • Ms. Maria Javaid, Section Officer, Women Development Department • Ms. Amna Aksheed, General Manager Grants, PPIF • Ms. Shamazat Babar, Grants Associate • Mr. Mansoor Riaz, Provincial Lead Punjab, Pathfinder International • Dr. Xaher Gul, Program Design & Strategy Advisor, Pathfinder International

Date	Output	Methods	Stakeholders Consulted
22 Apr 2024	• 2nd Draft of the SBC Strategy for FP/MNCH Punjab including strategy descriptions along with audience segmentation, communication and engagement objectives, and Interventional mapping by objective	• Review of current SBCC action plans for PWD Punjab • Incorporation of feedback received from TWG on Draft 1. • Draft 2 presented to TWG for PFPP DLI 4.1. • Feedback and consultation for alignment and next steps	Stakeholders Consulted • Ms. Saman Rai, Director General PWD • Dr. Hamza Tarar, Dy. Director IRMNCH & NP • Capt. (r), Dr. Usman Ali Khan, Health Specialist, Punjab Human Capital Investment Project, Addl. Program Director PFPP, P&SHD • Mr. Qudrat ullah, Director General PR • Mr. M. Afzal Chauhdhry, Dy. Director IEC, PWD • Ms. Sania Mirza, Asst. Director IEC, PWD • Mr. Muhammad Yahya, Section Officer, School Education Department • Mr. Basit Tahir, Secondary Education Department • Mr. Mansoor Riaz, Provincial Lead Punjab, Pathfinder International
13 May 2024	• 3rd Draft of the SBC Strategy for FP/MNCH Punjab including in addition to above, implementation framework, and mapping of activities to specific interventions	• Incorporation of feedback received from TWG on Draft 2. • Draft 3 presented to PFPP, IRMNCH & NP • Feedback provided, review of comments received from World Bank, and consultation for scope of revisions	Consultative review • Dr. Sabeen Nasir, Deputy Director IRMNCH & N Program • Capt. (r), Dr. Usman Ali Khan, Health Specialist, Punjab Human Capital Investment Project, Addl. Program Director PFPP, P&SHD • Mr. Hassan Iqbal Dogar, Asst DG, PWD • Mr. Mansoor Riaz, Provincial Lead Punjab, Pathfinder International • Dr. Xaher Gul, Program Design & Strategy Advisor, Pathfinder International • Document Review: World Bank Reviewers
31 May 2024	• 4th Draft of the SBC Strategy for FP/MNCH Punjab	• Incorporation of feedback received from stakeholders and World Bank reviewers on Draft 3. • Revised strategy document circulated to stakeholders and World Bank for final review and comments.	Reviewers • PWD • IRMNCH & NP • World Bank

Date	Output	Methods	Stakeholders Consulted
8 Jul 2024	• 5th Draft of the SBC Strategy for FP/MNCH Punjab revised to include preliminary action plans and financial outlays, and alignment with implementation plans, in the short term and long term.	• Review of comments received from World Bank • Consultation for scope of revision with stakeholders • Incorporation of feedback received from stakeholders and World Bank on Draft 4.	Stakeholders Consulted • Dr. Sabeen Nasir, Deputy Director IRMNCH & N Program • Capt. (r) Dr. Usman Ali Khan, Health Specialist, Punjab Human Capital Investment Project, Addl. Program Director PFPP, P&SHD • Mr. Hassan Iqbal Dogar, Asst DG, PWD • Dr. Xaher Gul, Program Design & Strategy Advisor, Pathfinder International • Ms. Ayesha Jafri, Sr. Program Advisor for SBC & Health Markets, Pathfinder International
13 Aug 2024	• SBC Strategy for FP/MNCH Punjab – final version for consultative action planning.	• Review of comments received from World Bank and consultation for scope of revision with stakeholders • Rapid desk review for supporting evidence. • Incorporation of feedback received on Draft 4	Stakeholders Consulted • Mr. Jahanzaib Sohail, Sr. Health Economist, World Bank • Mr. Ali Saeed Mirza, Health Specialist, HSAHP World Bank • Dr. Sabeen Nasir, Deputy Director IRMNCH & N Program • Mr. Hassan Iqbal Dogar, Asst DG, PWD • Dr. Xaher Gul, Program Design & Strategy Advisor, Pathfinder International • Ms. Ayesha Jafri, Sr. Program Advisor for SBC & Health Markets, Pathfinder International

Annex 2: Punjab SBC Strategy Action Plan[2]
Strategy 1.1: Increased adoption of family planning methods by women

S/No	APPROACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.1.0	Foundational Activities	Validation of Key Messages	Development of key messages for women	Set of theory informed, validated key messages for all influencer segments.	DG PWD / Pathfinder	25,000,000												
			Testing and validation of key messages															
			Printing and dissemination of key messages for informing IEC content.															
1.1.1	Community-based Health Education	Lady Health Workers	Development of strategy, activities & MEL	Provider training and capacity building sessions on validated thematically aligned key messages and IEC for LHWs for women	DPWO Office	161,280,000												
			Development of tailored IEC materials and job aids															
			Printing of content															
			Training and capacity development of CHW															
			Strengthen supportive supervision															
			Household visits															
			Neighborhood Meetings															
		Family Welfare Assistant	Development of strategy, activities & MEL	Provider training and capacity building	DPWO Office	20,160,000												
			Development of tailored IEC materials and job aids															

[2] All timelines and indicated costs are preliminary costing estimates based on refinements of scale, scope, and outputs of the different activities undertaken during Phases 1 and 2 of Strategy 3.3.

S/No	APPROACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Community-based Health Education	Community-based Health Education		Printing of content	sessions on validated thematically aligned key messages and IEC for FWAs for women														
			Training and capacity development of LHW															
			Strengthen supportive supervision															
			Household visits															
			Neighborhood Meetings															
		Paramedics & Homeopath/ Hakeems	Development of strategy, activities & MEL	Provider training and capacity building sessions on validated thematically aligned key messages and IEC for Paramedics, Hakeems and Homeopaths for women	DPWO Office	20,160,000												
			Development of tailored IEC materials and job aids															
			Printing of content															
			Training and capacity development of FWA															
			Strengthen supportive supervision															
			Household visits															
			Neighborhood Meetings															
		Community Midwives / TBA's	Development of strategy, activities & MEL	Provider training and capacity building sessions on validated thematically aligned key messages and IEC for community midwives /TBAs for women	DPWO Office	100,800,000												
			Development of tailored IEC materials and job aids															
			Printing of content															
			Training and capacity development of CHW															
			Strengthen supportive supervision															
			Household visits															
			Neighborhood Meetings															

S/No	APPROACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education	**Outreach by Providers**	Health Camps	Special IUCD, MSU free medical camps	DPWO Office	4,200,000												
			BHUs/ RHCs/ Community Gathering Centers	Family Planning Counters at BHUs, RHCs and community gathering centers	DPWO Office	60,480,000												
		Women's Community Events	Development of operational plan for activity & MEL	MEL plan in coordination with the vendors onboarded.		-												
			Community awareness sessions on international days	Celebrating the following days districts: World Population Day World Contraception Dat Blood Cancer / Pink Ribbon Dat World Aids Day Women's Day Independence Day	DG PWD/ DPWO Office	7,200,000												

S/No	Appr OACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education		Meena Bazaar / Family Melas	Meena Bazaar will contain competitions to increase engagement i.e. speech, painting, essay-writing, healthy baby, best married couples' competition, cooking, bouquet making, sewing competition etc.	DG PWD/ DPWO Office	201,600,000												
			Sehat Mela / Health Mela	Sehat / health melas - they will have stalls and exhibitions with key message branding.	DG PWD/PMIU /DPWO Office	201,600,000												
			Street Theatre	Community street theatre	DG PWD/PMIU /DPWO Office	58,060,800												
			Celebration of Family Planning Weeks with walks and rallies	Celebration of 'family planning weeks for women	DPWO Office	100,800,000												

S/No	Appr OACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education		Sukhi Ghar Mehfil or Community Group Meetings	Sukhi Ghar Mehfils i.e. community group meetings for women	DPWO Office	100,800,000												
		Youth female engagement at Universities for FP/RH	Development of detailed operational plan and MEL	Partnerships established with 25 universities including; GCU Lahore, LCWU Lahore, Kinnaird College Lahore, KEMU Lahore, Fatima Jinnah Medical University Lahore, Allama Iqbal Medical College Lahore, SIMS Lahore, Queen Marry College Lahore, UCP Lahore, UMT Lahore, NCA Lahore, FAST University Lahore, Qarshi University Lahore, UOL Lahore, BNU Lahore, Minhaj University Lahore, FC College Lahore, MAO College Lahore, Govt.	DG PWD/PMIU /DPWO Office	-												
			University Partnerships are established															

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education			Diyaal Singh College Lahore, LUMS Lahore, Leads University Lahore, LGS College Lahore, BZU Multan, IUB Bahawalpur, UOG Sargodha														
			Development, testing, validation and printing of university sport events branding with key messages for female engagement in FP/RH.	University sporting events in 25 universities of Punjab with branded with key messages. Sports events include cricket, football, wresting, kabaddi and other indoor sports	DG PWD/PMIU /DPWO Office	23,520,000												
			University sports events branded with key messages															
			Premarital Counselling sessions for young couples.	Premarital Counselling sessions held at universities.	DPWO Office	18,547,200												
			Seminars and Conferences	Seminars / conferences incorporate key themes at universities.	DGPWD	10,000,000												

S/No	APPROACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
			Lectures	Informative Lectures at Colleges & Universities with key themes	DPWO Office	3,024,000												
1.1.2	Community Signposting	Community Billboards	Development of strategy, activities & MEL	Hoardings, Streamers, Banners, Standees or SMDs in the community, with key messages aimed at women	DG PWD/ DPWO Office	22,200,000												
			Testing and validation of content for girls and women															
			Printing of content															
			Community deployment															
		Community Retail Spaces	Development of strategy, activities & MEL	Hoardings, Streamers, Banners, Standees or SMDs in the community, with key messages aimed at women														
			Printing of content															
			Testing and validation of content for girls and women															
			Community deployment															
		Public and Private sector owned Public Transport Signposting	Development of strategy, activities & MEL	Hoardings, Streamers, Banners, Standees or SMDs in retail spaces, with key messages aimed at women														
			Printing of content															
			Testing and validation of content for girls and women															
			Community deployment															
1.1.3	Mass Media Messaging	Radio	Development of strategy, activities & MEL	Jingle, PSA and radio shows,	DG PWD/PMU/ DPWO Office	80,000,000												

S/No	APPR OACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Mass Media Messaging		Finalization of content for radio	aimed at women, aired on popular channels such as FM 101, FM 93, Mera FM 107.4, MAST FM 103, FM 89.4, Awam FM 94, FM AWAZ, FM 100														
			Deployment															
		Television	Development of DVC and jingles (featuring societal influencers)	1 jingle maximum airtime over two years	DG PWD/PMIU DPWO Office	120,000,000												
			Airing of DVC and jingle	1 TVC maximum airtime over two years 48 TV talk shows over 2 years														
			Partnership with TV media channels for ongoing content on priority FP/RH themes	To be aired maximum times on the following channels GEO News, GEO Pakistan, ARY News- Bakhabar Sawera, HUM News- Subha sy agy, Express News- Expresso, Lahore Rang- Good Morning Lahore, AJJ News, SUNO TV, 92 HD														
			TV talk shows on priority FP/RH themes															

S/No	APPR OACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Mass Media Messaging			Targeted at men and women														
			TV Drama on priority FP/RH themes	1 TV drama	PPIF	608,640,000												
		Print media	Development of strategy, activities & MEL	Newspapers /Features/Columns/Special Supplements in prominent papers	DG PWD/ DPWO Office	734,040,000												
			Finalization of content for print															
			Deployment															
		SMS	Development of strategy, activities & MEL	TBD	TBD	TBD												
			Finalization of content for SMS	TBD	TBD	TBD												
			Deployment	TBD	TBD	TBD												
1.1.4	Digital - Social Media	Facebook / Instagram / TikTok / YouTube /	Onboarding of marketing agency for development of content	Static post, moving post, reels, testimonials	DG PWD/PMU / DPWO	88,000,000												
			Finalization of content															

S/No	APPROACH	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Digital - Social Media Messaging	**Twitter / Google**	Hiring of influencers Posting and boosting	(paid boost) for women														
		Virtual networks	Selection of community Youth Champions	TBD	TBD	TBD												
			Creation of virtual networks - WhatsApp	TBD	TBD	TBD												
			Key messages, IEC materials, PSAs, Videos disseminated	TBD	TBD	TBD												
TOTAL ESTIMATED PRELIMINARY COST						**PKR 2,770,112,000**												

Strategy 1.2: Increased adoption of male methods for family planning by men

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.2.0	Foundational Activities	Validation of Key Messages	Development of key messages for men	Set of theory informed validated key messages for all influencer segments.	DG PWD / Pathfinder	25,000,000												
			Testing and validation of key messages															
			Printing and dissemination of key messages for informing IEC content.															
1.2.1	Community-based Health Education	Lady Health Workers	Development of strategy, activities & MEL	Provider training and capacity building sessions on validated thematically aligned key messages and IEC for LHWs for men	DPWO Office	161,280,000												
			Development of tailored IEC materials and job aids															
			Printing of content															
			Training and capacity development of CHW															
			Strengthen supportive supervision															
			Household visits															
			Neighborhood Meetings															
		Family Welfare Assistant	Development of strategy, activities & MEL	Provider training and capacity building sessions on validated thematically aligned key messages and IEC for FWAs for men	DPWO Office	20,160,000												
			Development of tailored IEC materials and job aids															
			Printing of content															
			Training and capacity development of LHW															
			Strengthen supportive supervision															
			Household visits															
			Neighborhood Meetings															
			Development of strategy, activities & MEL	Provider training and	DP W	20,160,000												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education	Paramedics & Homeopath/ Hakeems	Development of tailored IEC materials and job aids	capacity building sessions on validated thematically aligned key messages and IEC for Paramedics, Hakeems and Homeopaths for men														
			Printing of content															
			Training and capacity development of FWA															
			Strengthen supportive supervision															
			Household visits															
			Neighborhood Meetings															
		Community Midwives / TBA's	Development of strategy, activities & MEL	Provider training and capacity building sessions on validated thematically aligned key messages and IEC for community midwives /TBAs for men	DPWO Office	100,800,000												
			Development of tailored IEC materials and job aids															
			Printing of content															
			Training and capacity development of CHW															
			Strengthen supportive supervision															
			Household visits															
			Neighborhood Meetings															
		Outreach by Providers	Health Camps	Special IUCD, MSU free medical camps	DPWO Office	4,200,000												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education		BHUs/ RHCs/ Community Gathering Centers	Family Planning Counters at BHUs, RHCs and community gathering centers	DPWO Office	60,480,000												
		Male Community Events	Development of operational plan for activity & MEL	MEL plan in coordination with the vendors onboarded.		-												
			Community awareness sessions on international days	Celebrating the following days districts: World Population Day World Contraception Dat Blood Cancer / Pink Ribbon Dat World Aids Day Women's Day Independence Day	DG PWD/ DPWO Office	7,200,000												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education		Meena Bazaar / Family Melas	Meena Bazaar will contain competitions to increase engagement i.e. speech, painting, essay- writing, healthy baby, best married couples' competition, cooking, bouquet making, sewing competition etc.	DG PWD/ DPWO Office	201,600,000												
			Sehat Mela / Health Mela	Sehat / health melas - they will have stalls and exhibitions with key message branding.	DG PWD/PMIU /DPWO Office	201,600,000												
			Street Theatre	Community street theatre	DG PWD/PMIU	58,060,800												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education		Celebration of Family Planning Weeks with walks and rallies	Celebration of 'family planning weeks for men	DPWO Office	100,800,000												
			Sukhi Ghar Mehfil or Community Group Meetings	Sukhi Ghar Mehfils i.e. community group meetings for men	DPWO Office	100,800,000												
		Youth Male engagement at Universities for FP/RH	Development of detailed operational plan and MEL	Partnerships established with 25 universities including: GCU Lahore, LCWU Lahore, Kinnaird College Lahore, KEMU Lahore, Fatima Jinnah Medical University Lahore, Allama Iqbal Medical College Lahore, SIMS Lahore, Queen Marry College Lahore, UCP Lahore, UMT Lahore, NCA Lahore,	DG PWD/PMIU /DPWO Office													
			University Partnerships are established															

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education			FAST University Lahore, Qarshi University Lahore, UOL Lahore, BNU Lahore, Minhaj University Lahore, FC College Lahore, MAO College Lahore, Govt. Diyaal Singh College Lahore, LUMS Lahore, Leads University Lahore, LGS College Lahore, BZU Multan, IUB Bahawalpur, UOG Sargodha													
			Development, testing, validation and printing of university sport events branding with key messages for female engagement in FP/RH.	University sporting events in 25 universities of Punjab with branded with key messages. Sports events include cricket, football,	DG PWD/PMIU /DPWO Office	23,520,000												
			University sports events branded with key messages															

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education			wresting, kabaddi and other indoor sports														
			Premarital Counselling sessions for young couples.	Premarital Counselling sessions held at universities.	DPWO Office	18,547,200												
			Seminars and Conferences	Seminars / conferences incorporate key themes at universities.	DGPWD	10,000,000												
			Lectures	Informative Lectures at Colleges & Universities with key themes	DPWO Office	3,024,000												
1.2.2	Community Signposting	Community Billboards	Development of strategy, activities & MEL	Hoardings, Streamers, Banners, Standees or SMDs in the community, with key messages aimed at men	DG PWD/ DPWO Office	22,200,000												
			Testing and validation of content for men															
			Printing of content															
			Community deployment															
		Community Retail Spaces	Development of strategy, activities & MEL	Hoardings, Streamers, Banners,														
			Printing of content															

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community Signposting	Public and Private sector owned Public Transport Signposting	Testing and validation of content for men	Standees or SMDs in the community, with key messages aimed at men														
			Community deployment															
			Development of strategy, activities & MEL	Hoardings, Streamers, Banners, Standees or SMDs in retail spaces, with key messages aimed at men														
			Printing of content															
			Testing and validation of content for men															
			Community deployment															
1.2.3	Mass Media Messaging	Radio	Development of strategy, activities & MEL	jingle, PSA and radio shows, aimed at men, aired on popular channels such as FM 101, FM 93, Mera FM 107.4, MAST FM 103, FM 89.4, Awam FM 94, FM AWAZ, FM 100	DG PWD/PMUI/ DPWO Office	80,000,000												
			Finalization of content for radio															
			Deployment															
		Television	Development of DVC and jingles (featuring societal influencers)	1 Jingle maximum airtime over two years 1 TVC maximum	DG PWD/PMIU DPWO Office	120,000,000												
			Airing of DVC and jingle															

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Mass Media Messaging		Partnership with TV media channels for ongoing content on priority FP/RH themes	airtime over two years 48 TV talk shows over 2 years														
			TV talk shows on priority FP/RH themes	To be aired maximum times on the following channels GEO News, GEO Pakistan, ARY News- Bakhabar Sawera, HUM News- Subha sy agy, Express News- Expresso, Lahore Rang- Good Morning Lahore, AJJ News, SUNO TV, 92 HD Targeted at men															
			TV Drama on priority FP/RH themes	1 TV drama	PPIF	608,640,000												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Mass Media Messaging	Print media	Development of strategy, activities & MEL	Newspapers /Features/Columns/Special Supplements in prominent papers	DG PWD/ DPWO Office	734,040,000												
			Finalization of content for print															
			Deployment															
		SMS	Development of strategy, activities & MEL	TBD	TBD	TBD												
			Finalization of content for SMS	TBD	TBD	TBD												
			Deployment	TBD	TBD	TBD												
1.2.4	Digital - Social Media Messaging	Facebook / Instagram / TikTok / YouTube / Twitter / Google	Onboarding of marketing agency for development of content	Static post, moving post, reels, testimonials (paid boost) for men	DG PWD/PMUI/ DPWO Office	88,000,000												
			Finalization of content															
			Hiring of influencers															
			Posting and boosting															
		Virtual networks	Selection of community Youth Champions	TBD	TBD	TBD												
			Creation of virtual networks - WhatsApp	TBD	TBD	TBD												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
			Key messages, IEC materials, PSAs, Videos disseminated	TBD	TBD	TBD												
TOTAL ESTIMATED PRELIMINARY COST						PKR 2,770,112,000												

Strategy 2: Shift household, community, and institutional social and gender norms to improve male engagement and reinforce individual agency and behavior change.

S/No	Approach	Channel	Activity	Outputs	Action By	Budget (PKR)	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2	Foundational Activities	**Validation of Key Messages**	Development of key messages for all influencer segments	Set of theory informed validated key messages for all influencer segments.	DG PWD / Pathfinder	25,000,000												
			Testing and validation of key messages for all influencer segments															
			Printing and dissemination of key messages for informing IEC content.															
2.1	Movement Building to Rally Societal Influencers	**Societal Influencers**	ii. Melad iii. Shan-e-Ramzan iv. Rehmat ul Aalamin Day Identification, engagement and mobilization of societal influencers.	Sensitization sessions with the stakeholders' groups; i. Lawyers, ii. Business Community, iii. NGOs / CSOS. iv. All Pakistani Ulema Council v. Journalists Vi. teachers / lecturers VII. Factory Workers/ Laborers/Kiln workers Farmers/ Domestic Workers MoU with all	DG PWD	151,200,000													

S/No	Approach	Channel	Activity	Outputs	Action By	Budget (PKR)	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Movement Building to Rally Societal Influencers																	
				Pakistan Ulema Council. Introductory and advocacy meetings will be conducted with religious clerics from each sect in partnership with the All-Pakistan Ulema Council.														
			Development of resources	Development of a resources for engagement of religious scholars i. Book/Guidance for Norm Shifting Advocates ii. Testimonials of religious clerics III. Development of Islamic declaration on FP by all sects	DG PWD	3,000,000												
			Capacity building and trainings to become advocates for FP/RH	Sensitization trainings with clerics with follow up / awareness sessions throughout the province.	DPWO Office	12,600,000												
			Activities are conducted for engagement of religious community.	Religious events conducted across Punjab such as i. Naat / Qira'at Competition	DPWO Office	151,200,000												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget (PKR)	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
				ii.Melad iii. Shan-e-Ramzan iv. Rehmat ul Aalamin Day														
			Organization of Dialogue and Action Planning Events (see below)	Request the religious and societal scholars to participate in provincial and district level activities for shifting social and gender norm	DPWO Office	50,400,000												
2.2	Community-based Health Education Events	Engagement Events	Community awareness sessions on commemorative days	Celebrating the following days in all 42 districts for 2 years (total 504 events) World Population Day World Contraception Dat Blood Cancer / Pink Ribbon Dat World Aids Day Women's Day Independence Day	DG PWD/ DPWO Office	3,600,000												
			Meena Bazaar / Family Melas	A total of 84 bazaars -1 per district for two years. Meena Bazaar will contain competitions to	DG PWD/ DPWO Office	100,800,000												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget (PKR)	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education Events			increase engagement i.e. speech, painting, essay- writing, healthy baby, best married couples' competition, cooking, bouquet making, sewing competition etc.														
			Sehat Mela / Health Mela	Sehat / health melas which will have stalls and exhibitions.	DG PWD/PMIU /DPWO Office	100,800,000												
			Celebration of Family Planning Weeks with walks and rallies	Family planning weeks for women with walks and rallies	DPWO Office	50,400,000												
			Sukhi Ghar Mehfil or Community Group Meetings	Sukhi Ghar Mehfils / Community Group Meetings	DPWO Office	50,400,000												
		Mother-in-Law Engagement Events	Development of strategy, activities & MEL	TBD	TBD	TBD												
			Finalization of content for print	TBD	TBD	TBD												
			Deployment	TBD	TBD	TBD												
		Intergenerational Dialogues	Development of strategy, activities & MEL	TBD	TBD	TBD												
			Finalization of content for print	TBD	TBD	TBD												
			Deployment	TBD	TBD	TBD												
		Participatory Mixed	Development of strategy, activities & MEL	252 street theatre for women. 3 per	DG PWD/PMI	29,030,400												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget (PKR)	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education Events	Community Theatre	Printing of content	district, per year, for 2 years.	U /DPWO Office													
			Testing and validation of content for girls and women															
			Street Theatre															
		Youth Engagement at Universities for shifting social and gender norms	Development of detailed operational plan and MEL	Partnerships established with 25 universities including; GCU Lahore, LCWU Lahore, Kinnaird College Lahore, KEMU Lahore, Fatima Jinnah Medical University Lahore, Allama Iqbal Medical College Lahore, SIMS Lahore, Queen Marry College Lahore, UCP Lahore, UMT Lahore, NCA Lahore, FAST University Lahore, Qarshi University Lahore, UOL Lahore, BNU Lahore, Minhaj University Lahore, FC College Lahore, MAO College Lahore, Govt. Diyaal Singh College Lahore, LUMS	DG PWD/PMIU /DPWO Office												
			University Partnerships are established															

S/No	Approach	Channel	Activity	Outputs	Action By	Budget (PKR)	Jul '24- Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-based Health Education Events			Lahore, Leads University Lahore, LGS College Lahore, BZU Multan, IUB Bahawalpur, UOG Sargodha														
			Development, testing, validation and printing of university sport events branding with key messages for female engagement in FP/RH.	46 university sporting events in 25 universities of Punjab are branded with key messages. Events include cricket, football, wrestling, kabaddi and other indoor sports	DG PWD/PMIU /DPWO Office	11,760,000												
			University sports events branded with key messages															
			Premarital Counselling sessions for young couples.	Premarital Counselling sessions	DPWO Office	9,273,600												
			Seminars and Conferences	16 seminars / conferences incorporate key themes.	DGPWD	5,000,000												
			Lectures	Informative Lectures at Colleges & Universities	DPWO Office	1,512,000												
2.3	Community Signposting	Community Billboards	Hoardings, Streamers, Banners, Standees or SMDs in the community, with key messages aimed at men	Hoardings, Streamers, Banners, Standees or SMDs in the community, with key messages aimed at men and women	DG PWD/ DPWO Office	11,100,000												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget (PKR)	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community Signposting	Community Retail Spaces	Hoardings, Streamers, Banners, Standees or SMDs in the community, with key messages aimed at men	Hoardings, Streamers, Banners, Standees or SMDs in the community, with key messages aimed at men and women														
		Public and Private sector owned Public Transport Signposting	Hoardings, Streamers, Banners, Standees or SMDs in retail spaces, with key messages aimed at men	Hoardings, Streamers, Banners, Standees or SMDs in retail spaces, with key messages aimed at men and women														
2.4	Mass Media Messaging	Radio	Development of Public Service Messages, Jingles etc. featuring societal influencers	Jingle, PSA and radio shows, aimed at women, aired on popular channels such as FM 101, FM 93, Mera FM 107.4, MAST FM 103, FM 89.4, Awam FM 94, FM AWAZ, FM 100	DG PWD/PMIU DPWO Office	40,000,000												
			Partnership with Radio media channels															
			Radio talk shows on priority FP/RH themes															
			High visibility media coverage															
		Print	Development of strategy, activities & MEL	Newspapers /Features/Columns/ Special Supplements in prominent papers	DG PWD/ DPWO Office	367,020,000												
			Finalization of content for print															
			Deployment															
		Television	Development of DVC and jingles (featuring societal influencers)	1 Jingle maximum airtime over two years	DG PWD/PMI	60,000,000												

	Activity	Outputs	Action By	Budget (PKR)	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Airing of DVC and jingle	1 TVC maximum airtime over two years 48 TV talk shows over 2 years To be aired maximum times on the following channels GEO News, GEO Pakistan, ARY News- Bakhabar Sawera, HUM News- Subha sy agy, Express News- Expresso, Lahore Rang- Good Morning Lahore, AJJ News, SUNO TV, 92 HD Targeted at men and women	U DPWO Office													
	Partnership with TV media channels for ongoing content on priority FP/RH themes															
	TV talk shows on priority FP/RH themes															
	TV Drama on priority FP/RH themes	1 TV drama	PPIF	304,320,000												
	Onboarding of marketing agency for development of content	Static post, moving post, reels, testimonials (paid boost) for men	DG PWD/PM UI/ DPWO Office	44,000,000												
	Finalization of content															
	Hiring of influencers															
	Posting and boosting															
TOTAL ESTIMATED PRELIMINARY COST				**PKR 1,582,416,000**												

Strategy 3.1: Strengthened Community-led social action, voice, & inclusion for supporting target FP/MNCH behaviors.

An activity set has been described for Strategy 3.1. Given that this approach is innovative for Punjab, especially at the envisioned scale, outputs and costing has not been undertaken. It is anticipated that the scale, scope, output, and costing specifications for Strategy 3.1 will be finalized consultatively with stakeholders and development partners during Phase 1 activities in Strategy 3.3.

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.1.1	Community led social action	Community Organization	CBO Mapping (including youth serving and youth led CBOs) in target districts	TBD	TBD	TBD												
			CBO selection and partnerships for leading district activities	TBD	TBD	TBD												
			CBOs establish and facilitate dialogue in Community Popular Opinion Leader (CPOL) forums	TBD	TBD	TBD												
			CBOs establish and facilitate dialogue target audience group forums	TBD	TBD	TBD												
3.1.2		CBO Capacity Strengthening	Training workshops to build capacity of CBOs & Community leadership	TBD	TBD	TBD												
			CBO-led Community Dialogue on priority FP/MNCH Issues	TBD	TBD	TBD												
			Co-design of Community-based events for AY, women, and men (1.1, 1.2, 2)	TBD	TBD	TBD												
			Co-design of Community Scorecard (CSC) approach with CBOs, incl. MEL	TBD	TBD	TBD												
			Co-design of District Community Dashboards for FP/MNCH incl. MEL	TBD	TBD	TBD												
			Co-design of CBO-supported Referral System for FP/MNCH incl. MEL	TBD	TBD	TBD												
3.1.3		CBO Social Action Planning	CBO Social Action Planning for CSC	TBD	TBD	TBD												
			CBO Social Action Planning for Community Dashboards	TBD	TBD	TBD												
			CBO Social Action Planning for hosting Community Actions Days	TBD	TBD	TBD												
3.1.4		CBO-Led Social Action	CBOs implement CSC approach	TBD	TBD	TBD												
			CBOs implement Community Dashboards for FP/MNCH	TBD	TBD	TBD												
			CBOs implement Community Actions Days	TBD	TBD	TBD												

Strategy 3.2. Provider Behavior Change (PBC) for delivering high quality, person-centered, respectful care for supporting target FP/MNCH behaviors.

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.2	Foundational Activities	Validation of Key Messages	Development of key messages for service providers	Set of theory informed validated key messages for service providers	DG PWD / Pathfinder	25,000,000												
			Testing and validation of key messages for service providers															
			Printing and dissemination of key messages for service providers															
3.2.1	Advocacy	Policy Level	Integrate FP standards and standards for Youth friendly services in HCC licensing checklist	TBD	TBD	TBD												
			Develop digital tools for HCC registration and quality assessments using updated checklists	TBD	TBD	TBD												
			Facilitate consultative review of new standards	TBD	TBD	TBD												
			Approval and notification of updated standards and checklists															
3.2.2	Institutional Capacity Strengthening	Institutional level	Train HCC staff on updated standards, checklists and tools	TBD	TBD	TBD												
			Pilot test updated quality assessment mechanism	TBD	TBD	TBD												
			Support scale up following pilot test	TBD	TBD	TBD												
			Identify gaps and develop solutions for supportive supervision for LHWs, FWA, Male Mobilizers, Service Providers	TBD	TBD	TBD												
			Implement supportive supervision solutions for LHWs, FWA, Male Mobilizers, Service Providers	TBD	TBD	TBD												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.2.3	Provider Behavior Change using Nai Umang solution	Provider level	Create provider networks (in-person & virtual discussions)	TBD	TBD	TBD												
			Conduct VCAT workshops	Capacity Building/Training / Workshops/Research development Leading to call of action - Social and Behavioral Change	DG PWD/PMIU PWTI/DPWO Office	21,000,000												
			Inter-personal communication/Counseling	Trainings	DG PWD/PMIU PWTI/DPW	200,000,000												
			Recognize and showcase peers and role models	TBD	TBD	TBD												
			Train and strengthen capacity of providers for delivering person-centered FP/MNCH counseling and care	TBD	TBD	TBD												
			Provide user friendly tools and guidelines for reinforcing good practices (e.g., PPFP)	TBD	TBD	TBD												
			Identify, recruit, train, mobilize and showcase provider role models using individual community and digital platforms	TBD	TBD	TBD												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
			Thematically align IEC materials using rational and emotional appeals to sensitize providers	TBD	TBD	TBD												
			Program rollout, tracking/reporting	TBD	TBD	TBD												
3.2.4	Community Scorecards	Community Level	CBO-led provider interface meetings using Community Scorecards	TBD	TBD	TBD												
			Dialogue sessions between CPOLs, Providers & Clients	TBD	TBD	TBD												
3.2.5	Client Empowerme	Client Level	Charters of client rights developed and posted across facilities	Posters	DG PWD/D PO	5,000,000												
			Client feedback systems, linked to Scorecards, developed and piloted	TBD	TBD	TBD												
TOTAL ESTIMATED PRELIMINARY COST						**PKR 251,000,000**												

Strategy 3.3: Strengthened Stewardship of efforts for improving service availability and utilization of target FP/MNCH services.

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.3.1	Community-Coalition Action at Provincial Level	**Phase 1: Strengthening Stewardship for SBC**	SBC Technical Working Group (TWG) Terms of Reference, Membership, Role and Responsibilities, and schedule of stewardship activities developed.	Joint Action plan for SBC TWG approved by competent Authority	DG PWD / Pathfinder International	16,100,000												
			1st Consultative Session with partners for review and consensus by stakeholders and partners.		DG PWD / Pathfinder International													
			SBC Technical Working Group ToRs, Membership, Role and Responsibilities, and schedule of activities notified by competent authority.		DG PWD													
			2nd Consultative Session for strategy review, validation, cocreation of Joint Action plan for SBC in Punjab, and defining metrics of success.		DG PWD / Pathfinder International													

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community-Coalition Action at Provincial Level	**Phase 2: Establish funding and financing mechanisms for FP/RH SBC**	Costed Implementation Plan for SBC in Punjab developed.	Punjab Costed Implementation Plan for FP/RH SBC Strategy approved by competent authority.	DG PWD / Pathfinder International	17,920,000												
			Fiscal Space Analysis undertaken for identifying funding gaps and financing solutions, including contributions for supporting activities.		DG PWD / Pathfinder International													
			3rd Consultative Session of SBC TWG to agree on SBC Costed Implementation Plan and pool of funded SBC Activities in Punjab.		DG PWD / Pathfinder International													
			Launch and Dissemination Event of the *Punjab SBC Costed Implementation Plan.*		DG PWD / Pathfinder International													
		Phase 3: Co-create activity designs, FP/RH Campaign, and Validation of IEC Materials	Activities for Phases 3, 4, and 5 will be defined and elaborated upon in the detailed costed implementation plan developed in Phase 2.	TBD	TBD	TBD												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		Phase 4: Steward SBC Strategy implementation & Monitor Progress	Activities for Phases 3, 4, and 5 will be defined and elaborated upon in the detailed costed implementation plan developed in Phase 2.	TBD	TBD	TBD												
		Phase 5: Establish evaluation mechanisms & Suggest course corrections	Activities for Phases 3, 4, and 5 will be defined and elaborated upon in the detailed costed implementation plan developed in Phase 2.	TBD	TBD	TBD												
3.3.2	**Community led advocacy for service delivery**	District Stewardship Platforms	CSO & CBO partners in districts included in District Implementation Platforms and notified	TBD	TBD	TBD												
			CSOs & CBOs participate and share implementation progress in District Health meetings	TBD	TBD	TBD												
		District level Stewardship Capacity Strengthening	CSO & CBO led capacity strengthening sessions with Implementers at District Level	TBD	TBD	TBD												
			CSO & CBO led value clarification sessions with Implementers at District Level	TBD	TBD	TBD												

S/No	Approach	Channel	Activity	Outputs	Action By	Budget	Jul '24- 'Jun 25				Jul '25 - Jun '26				Jul '26 - Jun '27			
							Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Community led advocacy for service delivery	Public-Private Dialogue	CSO & CBO-led Community Katchehry for showcasing, and celebrating Implementers delivering affirmative FP/MNCH stewardship	TBD	TBD	TBD												
			CSO & CBO partners in districts develop Stewardship Events Calendar	TBD	TBD	67,200,000												
			CSO & CBO-led Town Hall meetings using Community Dashboards for FP/MNCH															
			CSO & CBOs facilitate Joint facility and site visits with public private sector partners															
TOTAL ESTIMATED PRELIMINARY COST						**PKR 101,220,000**												

Annex 3:
Preliminary Estimated Cost, by Strategy

S/NO	STRATEGY	PRELIMINARY ESTIMATED COST (PKR)
1.1	Increased adoption of family planning methods by women	**2,770,112,000**
1.2	Increased adoption of male methods for family planning by men	**2,770,112,000**
2.1 & 2.2	Shift household, community, and institutional social and gender norms to improve male engagement and reinforce individual agency and behavior change	**1,582,416,000**
3.1	Strengthened Community-led social action, voice, & inclusion for supporting target FP/MNCH behaviors.	**TBD**
3.2	Provider Behavior Change (PBC) for delivering high quality, person-centered, respectful care for supporting target FP/MNCH behaviors.	**251,000,000**
3.3	Strengthened Stewardship of efforts for improving service availability and utilization of target FP/MNCH services.	**101,220,000**
4	Monitoring /Evaluation/Impact Assessments	**100,000,000**
	ESTIMATED PRELIMINARY COST (July 2024 – June 2027)	**7,574,860,000**

Annex 4: Preliminary Estimated Cost, by channel and medium

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
Preliminary Work	IEC	Creation, printing and distribution of IEC/SBCC Materials	DG PWD/PMIU /DPWO Office	100,000,000	1	1	1	100,000,000	All IEC material printing	1.10, 1.20, 2.10, 2.20
Preliminary Work	IEC	Charter of rights at all the clinics	DG PWD/PMIU /DPWO Office	5,000,000	1	1	1	5,000,000	Boards at all the clinics	3.2.5
Preliminary Work	MLE	Monitoring /Evaluation/Impact Assessments	DG PWD/PMIU /DPWO Office	100,000,000	1	1	1	100,000,000	MLE mechanism for 4 years	N/A
Preliminary Work	Phase 1	Phase 1: Strengthening Stewardship for SBC	DG PWD / Pathfinder International	16,100,000	1	1	1	16,100,000	Joint Action plan for SBC TWG approved by competent Authority	3.3.1
Preliminary Work	Phase 2	Phase 2: Establish funding and financing mechanisms for FP/RH SBC	DG PWD / Pathfinder International	17,920,000	1	1	1	17,920,000	Punjab Costed Implementation Plan for FP/RH SBC Strategy approved by competent authority.	3.3.1
Mass Media	Television	Drama/Telefilm	PPIF	300,000,000	1	1	1	300,000,000	1 TV Drama for male and female engagement	1.1.3, 1.2.3 & 2.4

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
Digital Media	Social media	Face Book, Twitter, LinkedIn, Instagram, TikTok, /YouTube/What's App /Activities/Website/ Khushi ki Baat App/Hamrah Application/ What s App	DG PWD/PMUI/ DPWO office	200,000,000	1	1	1	200,000,000	Static post, moving post, reels, testimonials (paid boost) for men	1.1.4, 1.2.4 & 2.5
Mass Media	Television	Talk shows	DG PWD/PMIU DPWO office	1,300,000	5	36	1	234,000,000	5 shows per month for 3 years (total 180 shows)	1.1.3, 1.2.3 & 2.4
		Retainer for maximum spots for TVC and jingle		1,287,600,000	0	0	0	1,287,600,000	1 Jingle maximum airtime over two 1 TVC maximum airtime over two years	1.1.3, 1.2.3 & 2.4
Mass Media	Radio	Talk shows	DG PWD/PMIU DPWO office	100,000	20	24	1	48,000,000	4 shows per month on 5 channel for 2 years (total 480 shows) on the following channels i.e. FM 101, FM 93, Mera FM 107.4, MAST FM 103, FM 89.4, Awam FM 94, FM AWAZ, FM 100	1.1.3, 1.2.3 & 2.4

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
		Retainer on channels for maximum spots for key messages and jingle		152,000,000	1	12	1	152,000,000	Jingle, PSAs aired	1.1.3, 1.2.3 & 2.4
Print	Newspapers	Articles, columns, special supplements	DG PWD/ DPWO office	1,835,100,000	1	24	1	1,835,100,000	Publications in newspapers /features/columns/special Supplements - highlighting key messages, influencer quotes and call-to-action	1.1.3, 1.2.3 & 2.4
Out of home (OOH)	Boards	Hoardings, Streamers, Banners, Standees/SMDs	DG PWD/ DPWO office	55,500,000	1	12	42	55,500,000	Hoardings, Streamers, Banners, Standees/SMDs - highlighting key messages, influencer quotes and call-to-action. To be done in all the districts.	1.1,2, 1.2.2, 2.3
Inter-personal communication	Outreach to Stakeholders for sensitization and orientation	NGO's & CBOs	DPWO Office	150,000	2	12	42	151,200,000	Total 1,006 sensitization sessions. 2 per month, over 1 year in all the	2.1
		Journalist & Columnist								
		Teachers & Lecturers								

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
Inter-personal communication		Factory Workers/ Laborer/Kiln workers Farmers/ Domestic Workers							districts. I. Lawyers, ii. Business Community, iii. NGOs / CSOS. iv. All Pakistani Ulema Council v. Journalists Vi. teachers / lecturers VII. Factory Workers/ Laborer/Kiln workers Farmers/ Domestic Workers MoU with all Pakistan Ulema Council. Introductory and advocacy meetings will be conducted with religious clerics from each sect in partnership with the All-Pakistan Ulema Council.	
		Imam & Khateeb & Nikah Khawan								

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
Inter-personal communication	Community awareness sessions	Premarital Counselling Sessions at public/ private Universities/colleges campuses		46,000	1	24	42	46,368,000	1,008 premarital counselling sessions over 2 years, 1 per month in each district at universities and colleges.	1.1.1, 1.2.1, 2.2
		LHW & LHS		40,000	8	24	42	322,560,000	14,112 counselling sessions over 2 years for providers.	1.1.1, and 1.2.1
		Community midwives/ Traditional Birth Attendants (TBA's)		40,000	5	24	42	201,600,000		1.1.1, and 1.2.1
		Family Welfare Assistants		40,000	1	24	42	40,320,000		1.1.1, and 1.2.1
		Paramedics & Homeopath/Hakeems		40,000	1	24	42	40,320,000		1.1.1, and 1.2.1
		World population Day	DG PWD/ DPWO Office	1,000,000	1	1	3	3,000,000	Celebrating the following 6 commemorative days in 3 main districts for 2 years (total 432 events) World Population Day World Contraception Dat Blood Cancer / Pink Ribbon Dat World Aids Day Women's Day	1.1.1, 1.2.1 & 2.2
		World Contraceptive Day		1,000,000	1	1	3	3,000,000		
		Independence Day		1,000,000	1	1	3	3,000,000		
		Blood Cancer Day/ Pink ribbon Day		1,000,000	1	1	3	3,000,000		
		World Aids Day		1,000,000	1	1	3	3,000,000		
		Women Day		1,000,000	1	1	3	3,000,000		

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
									Independence Day	
Inter-personal communication	Events	Celebration of Family Planning Weeks with walks and rallies.	DPWO Office	500,000	1	12	42	252,000,000	504 family planning weeks in 42 districts, 1 per district per month for 1 year.	1.1.1, & 1.2.1 & 2.2
		Health Melas / Sehat Melas (stalls, cricket, football, kabaddi, wrestling)	DG PWD/ DPWO Office	1,500,000	1	8	42	504,000,000	Total 336 sehat / health melas - 4 per year, per district for a period of 2 years. It will have stalls and exhibitions as well.	1.1.1, & 1.2.1 & 2.2
		Sports	DPWO Office	175,000	1	8	42	58,800,000	Total 336 sports events. 1 events per district, per quarter, over 2 year. Events include cricket, football, wresting, kabaddi and other indoor sports	1.1.1, 1.2.1 & 2.2
		Sukhi Ghar	DG PWD/PMIU /DPWO Office	50,000	5	24	42	252,000,000	5040 Sukhi Ghar Mehfils (community group meetings for women). 5 per month, per district for 2 years.	1.1.1, 1.2.1 & 2.2

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
Inter-personal communication		Street Theatre	DG PWD/PMIU /DPWO Office	288,000	1	12	42	145,152,000	504 street theatre performances, 1 per district, per year, for 1 year. Total 336 bazaars -1 per district, per quarter, for two years. Meena Bazaar will contain competitions to increase engagement i.e. speech, painting, essay- writing, healthy baby, best married couples' competition, cooking, bouquet making, sewing competition etc. All themes will have key messages and branding.	1.1.1, 1.2.1 & 2.2
		Meena Bazaar / Family Melas	DG PWD/ /DPWO Office	1,500,000	1	8	42	504,000,000		1.1.1, 1.2.1 & 2.2

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
Inter-personal communication		Religious Events	DPWO Office	300,000	1	12	42	151,200,000	504 religious events conducted annually across Punjab, 1 per month, per district, for 1 year. Events comprising 1 each of; I. Naat / Qira'at Competition ii.Melad iii. Shan-e-Ramzan iv. Rehmat ul Aalamin Day	2.1
				3,000,000	1	1	1	3,000,000	Development of resources for engagement with religious scholars.	2.1
				150,000	1	2	42	12,600,000	Capacity building and trainings to become advocates for FP/RH. One Training per year per district (total 84)	2.1

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
				50,000	2	12	42	50,400,000	Total 1008 sessions - 2 event per district per month for 1 years. In the event religious scholars and societal scholars participate in provincial and district level activities for shifting social and gender norm	2.1
Inter-personal communication	Colleges/ Universities/Community Centers	Informative Lectures at Colleges & Universities	DPWO Office	15,000	1	12	42	7,560,000	1 lecture per month per district for over a year (total 504)	1.1.1, 1.2.1 & 2.2
		Seminar/ Conference	DG PWD	500,000	50	1	1	25,000,000	50 seminars organized at various universities throughout the programme.	1.1.1, 1.2.1 & 2.2
Advocacy	Workshops/Conferences	Advocacy and Awareness with politicians & political parties	DG PWD/PMIU /DPWO Office	200,000	1	8	42	67,200,000	4 sessions per quarter, per district for a period of 2 years (total 336)	3.3.2

Medium	Channel	Subcategory	Responsibility	Unit Cost	Quantity (per month)	Period (months)	Number of Districts	Budget (PKR)	Output	Activity Plan reference
Capacity Building	Provider Behaviour Change	Capacity Building/Training / Workshops/Research development Leading to call of action -Social and Behavioral Change	DG PWD/PMIU PWTI/DPWO Office	100,000	5	1	42	21,000,000	5 VCAT workshops per district spread over 3 years (total 210)	3.2.3
Inter-personal communication	Counseling	Outreach mobilization	DPWO Office	-	0	0	0	200,000,000	Nai Umang solution for PBC	3.2.3
Inter-personal communication	Outreach	Special IUCDs & MSU / Free Medical Camps	DPWO Office	50,000	1	4	42	8,400,000	1 camp per quarter per district (total 168 camps)	1.1.1 & 1.2.1
Inter-personal communication	BHUs/ RHCs/ Community Gathering Centers	Family Planning Counters	DPWO Office	40,000	3	24	42	120,960,000	Staff cost for running FP counters at BHU's, RHCs, Community Gathering Centers for 2 years. Total 126 running over 2 years.	1.1.1 & 1.2.1
Digital Media	Social media	Engagement of Social Media Influencer/ Campaigner/ Youtuber/Tik Toker/	DG PWD/PMIU /DPWO Office	20,000,000	0	24	0	20,000,000	Cost of social media influencers.	1.1.4, 1.2.4 & 2.5
ESTIMATED PRELIMINARY COST								PKR 7,574,860,000 +		

POPULATION WELFARE DEPARTMENT
Government of Punjab

Punjab Family Planning Program

Primary & Secondary Healthcare Department

Qadam Ba Qadam
قدم بہ قدم

PATHFINDER