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# Social & Behavior Change (SBC) Strategy for Family Planning and Reproductive, Maternal, Newborn and Child Health in Sindh

SINDH



# **Social & Behavior Change (SBC) Strategy for Family Planning and Reproductive, Maternal, Newborn and Child Health in Sindh**

**October 2025**

FP2030 Secretariat  
Population Welfare Department  
Government of Sindh

## **DISCLAIMER**

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# Foreword

As Sindh progresses toward its FP2030 commitments and broader reproductive, maternal, newborn, and child health (RMNCH) goals, it is imperative that we move beyond traditional awareness-raising efforts and embed social and behavior change (SBC) as a core function of our health systems. This strategy is a response to that imperative.

Developed through a highly participatory, evidence-informed process, this SBC Strategy for FP/RMNCH represents a collective vision of the Government of Sindh—anchored in the leadership of the Population Welfare Department and the Department of Health and supported by the insights and efforts of a wide array of stakeholders. It brings forward a unified, provincial roadmap to guide sustained, high-impact behavior change interventions that are contextually grounded and systemically integrated.

We are confident that this Strategy will serve as a foundational resource for government institutions, development partners, civil society, academia, and community leaders alike. It provides the necessary frameworks, tools, and direction to translate vision into action—ensuring that no one is left behind.

We extend our sincere appreciation to all those who contributed to the development of this strategy and reaffirm our commitment to its implementation. Together, we can make behavior change a driving force for transforming health across Sindh.



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**Dr. Azra Fazal Pechuho**

Minister for Health and Population  
Government of Sindh

The Population Welfare Department is proud to present the Sindh Social and Behavior Change Strategy for FP/RH, a foundational resource that reinforces our commitment to achieving sustainable population and reproductive health goals.

We recognize that achieving our FP/RH goals demands more than expanded services or improved logistics. It requires a fundamental shift in how individuals, families, and communities think, feel, and act in relation to family planning.

I extend my gratitude to all the stakeholders who contributed to this process—government departments, local organizations, donors, and community members. This strategy is the product of your collaboration, expertise, and shared commitment.

Moving forward, the Population Welfare Department remains dedicated to translating this strategy into action through coordinated planning, sustained investment, and strong provincial leadership. Together, we can create a future where every individual in Sindh can access and choose family planning services without barriers or stigma.



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**Mr. Hafeezullah Abbasi**

Secretary

Population Welfare Department

Government of Sindh

The health and well-being of the people of Sindh is the bedrock of our development agenda. As we work toward achieving universal health coverage, it is imperative that our efforts go beyond service delivery and address the underlying behavioral, social, and structural determinants that shape reproductive health outcomes.

This Social and Behavior Change (SBC) Strategy for FP/RMNCH is a critical step forward in that direction. Anchored in evidence and developed through extensive consultation, the strategy recognizes that access to services alone is not enough. We must transform the norms, attitudes, and decision-making dynamics within households and communities to create an enabling environment for family planning and reproductive health.

The Health Department remains committed to ensuring that family planning is fully integrated into maternal, newborn, and child health services across all levels of care. We are particularly focused on promoting postpartum family planning, strengthening provider-client interactions, and ensuring that quality of care reflects the dignity and rights of every individual.

As this strategy is operationalized, I call on our health professionals, district managers, and partners to collaborate closely and act boldly.



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**Mr. Rehan Iqbal Baloch**  
Secretary  
Department of Health  
Government of Sindh

I am glad to present the Sindh Social and Behavior Change Strategy for FP/RH – a critical instrument to ensure FP2030. This strategy operationalizes the behavioral dimensions of the FP2030 commitments by transforming how individuals, families, and communities understand, value, and engage with reproductive health.

Recognizing that behavior change is shaped by a complex interplay of social norms, cultural beliefs, and interpersonal relationships, this strategy provides a robust, locally tailored framework. It outlines strategic, evidence-based approaches to meaningfully engage youth, men, community leaders, service providers, decision makers and policy makers. It sets a clear course to overcome resistance, shift harmful norms, and advance reproductive autonomy and rights.

I extend my sincere appreciation to the Population Welfare Department, Department of Health, our dedicated partners, and the many stakeholders whose insights, experience, and support have shaped this important milestone. Let me appreciate the efforts and collaboration of Pathfinder International with CIP/PWD to develop and finalize the Strategy.



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### **Dr. Talib Lashari**

Technical Advisor, CIP/FP2030  
Population Welfare Department  
Government of Sindh

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# 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 Officer
FP	Family Planning
FWA	Family Welfare Assistants
GoS	Government of Sindh
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	Interpersonal 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
MWRA	Married Women in Reproductive Age
NGO	Non-Governmental Organization
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
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SEM	Social Ecological Model
TFR	Total Fertility Rate
TNSB	Theory of Normative Social Behavior
VCAT	Value Clarification and Attitude Transformation
WHO	World Health Organization

# Executive Summary



This Social and Behavior Change (SBC) Strategy for Family Planning and Reproductive, Maternal, Newborn, and Child Health (FP/RMNCH) in Sindh has been developed under the leadership of the Population Welfare Department (PWD), Government of Sindh, and the FP2030 Secretariat, with support from diverse stakeholders. It serves as a unified, evidence-informed blueprint to achieve Sindh’s ambitious FP2030 commitments, notably raising the modern contraceptive prevalence rate (mCPR) from 30% to 47% by 2025 and to 57% by 2030.

The document is organized into four sections: an Introduction that sets out the vision, objectives, and methodology; a Diagnosis and Needs Assessment that analyzes key behavioral, social, and systemic gaps; the Sindh SBC Strategy which outlines three interlinked approaches to support intention, shift norms, and strengthen enabling structures; and an Implementation, Monitoring, Evaluation, and Learning section that lays out the phased roll-out plan, learning agenda, and accountability mechanisms.

The introduction anchors the strategy in the mission of the Department of Health (DoH) and PWD Sindh, linked to universal health coverage and the Sustainable Development Goals, with Sindh aspiring to become a national leader by 2030 through reduced maternal and infant mortality, increased uptake of modern contraceptives, and improved birth spacing. It presents the strategy’s purpose as providing a unified SBC framework to enhance leadership, foster individual and community ownership of healthy behaviors, and promote scale-up of localized interventions tailored to Sindh’s diverse needs. It also outlines what is included—such as a holistic SBC framework, priority audiences, communication objectives, interlinked intervention sets, and an implementation framework—and identifies the intended users across government, frontline providers, partners, community leaders, and academia.

The Diagnosis and Needs Assessment describes Sindh’s youthful, urbanizing, yet socioeconomically diverse population, with disparities across urban and rural settings and persistent gaps in education, income, and health outcomes. It highlights high fertility rates, substantial unmet need, low rates of FP counseling during facility visits, and high contraceptive discontinuation due to side effects and weak counseling.

It identifies predisposing factors such as knowledge gaps and low agency, reinforcing factors like restrictive gender norms and family pressures, and enabling factors including fragmented SBC systems, funding constraints, and limited data. Annexes provide detailed data profiles of users, intenders, and non-intenders that have directly informed the strategy’s focus.

The Sindh SBC Strategy is structured around three interconnected approaches.

**Strategy 1** focuses on supporting informed decision-making by individuals by addressing predisposing factors through interpersonal communication, community activities, mass media, digital platforms, SMS campaigns, and improving health literacy—tailored by life stage for MWRA, men, adolescents, and youth.

**Strategy 2** aims to shift social and gender norms by engaging households, communities, and institutions to reinforce supportive norms around spousal communication, shared decision-making, and family planning, using approaches such as community theatre, seminars, small group meetings, and leveraging opinion leaders.

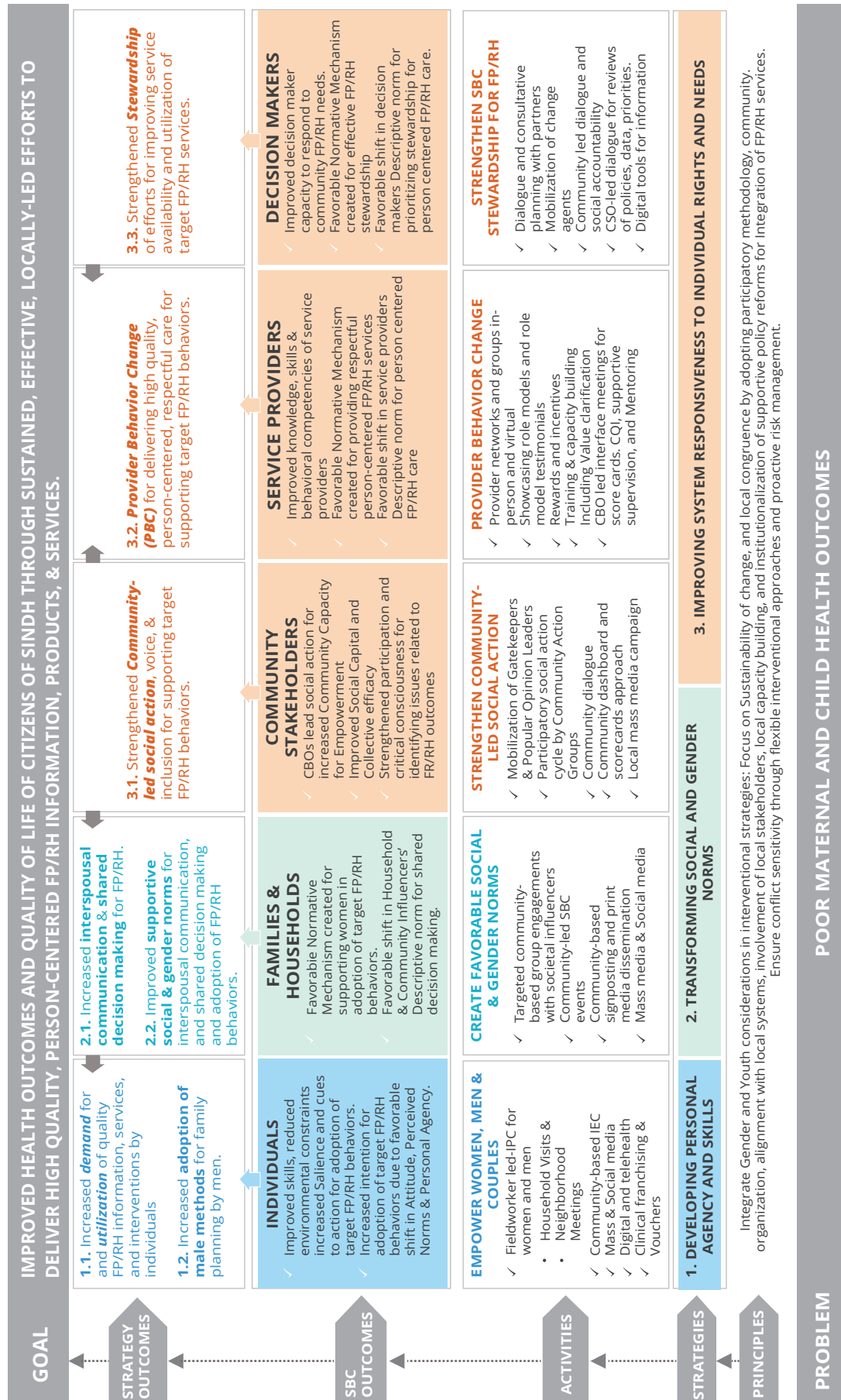
**Strategy 3** works to strengthen structural and institutional enablers through community-led social action, institutionalizing Provider Behavior Change (PBC) for respectful, person-centered care, and advancing stewardship through mechanisms like the FP2030 Working Group, with integration of family planning into the Essential Package of Health Services (EPHS) pilot in Tando Allahyar illustrating this systemic effort.

The Implementation Framework emphasizes phased, costed roll-out aligned with Sindh's FP2030 Roadmap, adaptable to district-specific realities and existing platforms, to promote sustainability and local ownership. It facilitates stakeholder engagement, resource alignment, and mapping of technical expertise across intervention types.

The Monitoring, Evaluation, and Learning (MEL) plan outlines key indicators to track changes in individual behaviors, service integration, and social norms, supported by mixed-methods evaluations that will guide adaptive programming and continuous learning.

This strategy represents a significant milestone for Sindh, offering a comprehensive technical resource to guide co-created operational plans and catalyze multi-level action. By embedding SBC into health systems, amplifying community voices, and fostering collaborative stewardship, Sindh is well-positioned to accelerate progress toward its FP2030 goals, transform social and gender norms, and secure healthier futures for women, men, and families across the province. Figure 1 presents the overarching results framework for the strategy.

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



# Introduction



## Section 1: Introduction

### Vision

This SBC Strategy is grounded in the mission of the Department of Health (DoH) and Population Welfare Department (PWD) Sindh and aligns with the province's broader health vision to ensure equitable, accessible, and high-quality services for all. It builds on the Government of Sindh's (GoS) commitment to universal health coverage and Pakistan's obligations under the Sustainable Development Goals (SDG's). By 2030, Sindh aspires to emerge as a national leader in achieving transformative FP/RMNCH outcomes, marked by significant reductions in maternal and infant mortality, increased uptake of modern contraceptives, and improved birth spacing. This will be achieved through a sustained focus on behavior change, service accessibility, and community-driven approaches. Based on this, the vision of the strategy is as follows:

**By 2030, Sindh becomes a national leader in achieving essential RMNCH and FP outcomes, significantly reducing infant and maternal mortality through birth spacing and uptake of contraceptives in alignment with Pakistan's commitments to the United Nations Sustainable Development Goals (SDGs)**



### Purpose

This strategy provides a unified SBC framework to guide coordinated, evidence-based action across sectors and stakeholders. It sets the foundation for a shared vision and strategic direction by:

- ▼ **Enhancing leadership, coordination, and institutional capacity** to embed SBC within health systems and policies.
- ▼ **Fostering individual and community ownership** of healthy behaviors that are contextually and culturally resonant.
- ▼ **Promoting the scale-up of localized, evidence-informed interventions** tailored to the diverse needs of Sindh's population.

Ultimately, the strategy aims to cultivate an enabling environment where individuals and communities, especially women, youth, and underserved groups—are empowered to make informed reproductive health choices. By integrating behavioral science, community engagement, and system-level reforms, the strategy contributes to improving health outcomes, advancing gender equity, and ensuring no one is left behind.

## What's Included

This strategy provides strategic direction for stakeholders in Sindh working on SBC for FP and MNCH by offering the following core elements:

- ▼ **A Holistic SBC Framework** to establish strong theoretical underpinnings that guide strategy selection and intervention design based on priority audiences and program resources.
- ▼ **Priority Audiences and Segments** mapped across the health system, enabling full integration of SBC with broader health system strengthening efforts.
- ▼ **Communication and Engagement Objectives** that are theory-driven, adaptable to a range of FP/MNCH behaviors, and measurable to track progress.
- ▼ **Interlinked Channel Mix and Intervention Sets** tailored for each audience type, providing a menu of options for stakeholders to use in developing SBC plans.
- ▼ **An Implementation Framework** organized by intervention type to facilitate stakeholder coordination, resource alignment, and expertise mapping.

## Intended Users

This strategy is designed for wide application across Sindh. However, the following key groups have been identified as the primary users:

- ▼ **Provincial Government officials** - Includes the DoH, PWD, district-level administrations, and allied provincial agencies. They will leverage this strategy for policymaking, resource allocation, and program oversight.
- ▼ **Health managers and frontline workers** - Includes Lady Health Workers (LHWs), Lady Health Supervisors (LHS), facility staff, EPI coordinators, and community-based organizations. They will implement targeted SBC interventions – such as counseling, outreach, and community mobilization – based on the strategy's guidelines.
- ▼ **Development partners, NGOs, and donors** - Includes bilateral and multilateral agencies, local NGOs, and private-sector CSR sponsors that fund or offer technical assistance for FP/RMNCH. They will use this document to harmonize their efforts with provincial health priorities.
- ▼ **Community Leaders, Religious Elders, and Civil Society Activists** - Individuals with significant social influence, who can shift norms, support the enforcement of protective laws (e.g., on child marriage), and champion healthy practices in both rural and urban settings.
- ▼ **Academia and Research Institutions** - Universities, training centers, and researchers will apply the strategy's frameworks to enhance SBC curricula, build local capacity, and conduct monitoring or operational research that refines ongoing FP/RMNCH programs.

# Background, Methods, and Needs

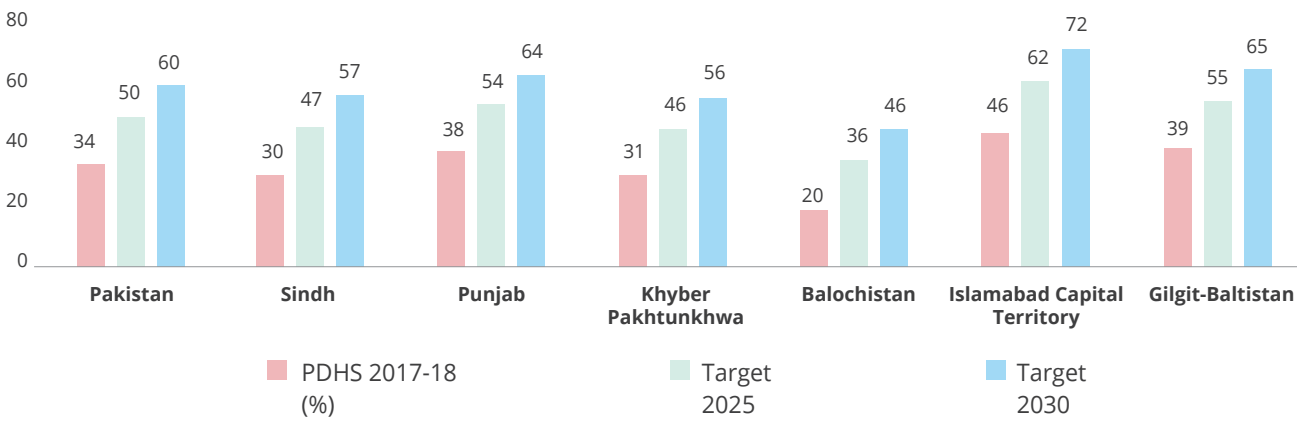


## Section 2: Background, Methods, And Needs

### National FP2030 Commitments

Pakistan has endorsed an ambitious set of FP2030 commitments that aim to transform family planning outcomes nationwide. At the core of these commitments is the goal to raise the modern contraceptive prevalence rate (CPR) from 34 percent in 2017-18 to 50 percent by 2025, and further to 60 percent by 2030 (Figure 2). These targets provide a unified vision for improving reproductive health, addressing unmet need, and lowering fertility rates across the country

**Figure 2: National and Provincial FP2030 Commitments - Contraceptive Prevalence Rate (CPR) (%)**



The Government of Pakistan has defined a clear set of priority objectives to steer progress toward these commitments. These include adopting progressive policy reforms supported by political will, ensuring universal access to family planning services to reduce fertility rates and meet unmet needs, and expanding information and services particularly to underserved and remote areas. The national framework also emphasizes the importance of a unified narrative on family planning, securing contraceptive commodity supply chains, strengthening legislative backing, institutionalizing system and human resource development, and embedding robust monitoring and evaluation mechanisms. Critically, it underscores the need for sustained financial mobilization to fund FP and reproductive health initiatives.

### Sindh FP2030 Commitments

Sindh has demonstrated strong provincial leadership by setting ambitious FP2030 commitments to raise its CPR from 30 percent to 47 percent by 2025, and to 57 percent by 2030 (Figure 2).<sup>1</sup> These targets reflect Sindh’s determination to advance family planning outcomes in alignment with national priorities, while responding to its unique socio cultural, economic, and demographic context. As home to nearly a quarter of Pakistan’s population, Sindh’s commitments are pivotal to achieving the country’s overall FP2030 goals. By articulating its FP2030 Roadmap, Sindh has taken an important step toward translating these commitments into actionable strategies, laying the foundation for more tailored, inclusive, and effective family planning initiatives across the province.

## Sindh FP2030 Roadmap

Sindh's Family Planning 2030 Vision sets out an ambitious agenda to reshape the lives of women, men, girls, youth, and adolescents, spanning from remote rural areas to urban centers, through rights based, multi sectoral action. By prioritizing women's empowerment, improved access to quality modern contraceptives, supportive legislation, life skills, health, and hygiene, the vision aims to transform social and gender norms as a hallmark of a progressive society. To operationalize this vision, the FP2030 Roadmap outlines nine core objectives, which together address system-wide reforms and service delivery priorities.

### SINDH FP2030 OBJECTIVES

1. Consolidate reforms
2. Integrated services and public private partnerships
3. Engaging youth and newlyweds
4. Improved quality of care
5. Advocacy and SBC in all interventions
6. Enabling systems
7. Multisectoral approaches
8. Engaging men and shifting social and gender norms
9. System strengthening for results

## SBC Specific Objectives in the FP2030 Roadmap

Among these, three objectives are directly focused on social and behavior change (SBC), which are critical to achieving the broader FP2030 vision:

- ▼ **Objective 3: Engaging youth and newlyweds**, ensuring that tailored approaches address the unique needs and life transitions of these groups.
- ▼ **Objective 5: Embedding advocacy and SBC across all interventions**, so that behavior change is not treated as a parallel stream but fully integrated into FP and RMNCH efforts.
- ▼ **Objective 8: Engaging men and shifting social and gender norms**, recognizing that sustainable change requires addressing the attitudes and behaviors that shape family planning decisions.

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, along with systemic and contextual factors, including the behaviors of others, influence people's ability to deliberate, decide, attempt, practice, and then sustain various behaviors that have an impact on health.

For effective SBC interventions which produce sustained social and behavior change, programs need to consider core SBC principles 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. How effectively these behavior centered objectives are implemented will determine the province's success in meeting its FP2030 targets.

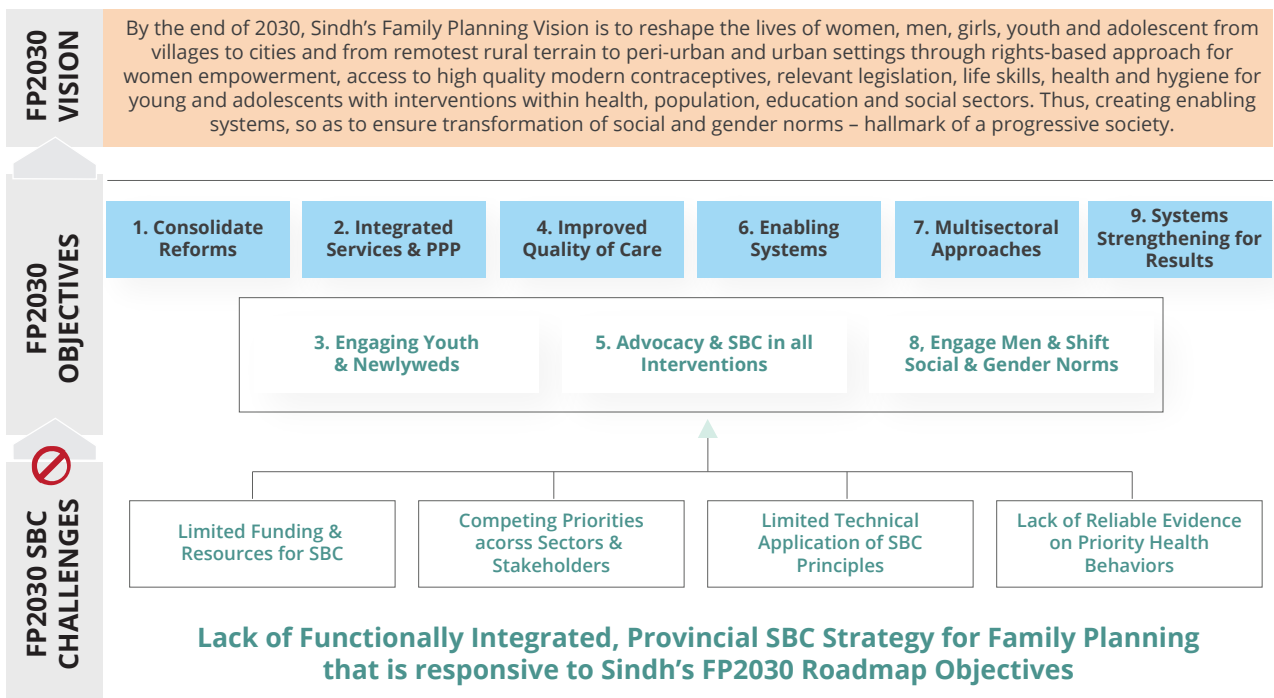
## Systemic Challenges to Achievement of FP2030 SBC Objectives

Despite this clear roadmap, Sindh faces some systemic challenges which have historically limited the ability of SBC investments in the province to achieve sustained and transformative outcomes. These include:

- ▼ **Limited Funding and Resources for SBC:** Most SBC activities rely on short term, project-based funding, limiting their reach and continuity. This makes it difficult to sustain efforts needed to drive long term shifts in family planning attitudes and behaviors.
- ▼ **Competing Priorities Across Sectors and Stakeholders:** Diverse institutional mandates and shifting priorities dilute collective focus on SBC, fragmenting investments and slowing the implementation of joint initiatives essential for integrated FP programming.
- ▼ **Limited Technical Application of SBC Principles:** Many programs continue to reduce SBC to awareness-raising alone, without applying robust behavior change theories and frameworks that can target underlying determinants and ensure measurable change.
- ▼ **Lack of Reliable Evidence on Priority Health Behaviors:** Insufficient data systems and minimal research on behavioral drivers make it hard to monitor progress, refine interventions, or build an evidence base that can guide strategic investment.

All these issues stem from a foundational gap, **the absence of a functionally integrated, provincial SBC strategy for family planning that is explicitly responsive to Sindh’s FP2030 roadmap objectives.** This strategy has therefore been designed to fill this critical void, unlocking coordinated action and accelerating progress toward Sindh’s family planning vision.

*Figure 3: Systemic Challenges to Achievement of FP2030 SBC Objectives*



## Methodology for SBC Strategy Development

The Sindh SBC Strategy was developed through an iterative, evidence driven, and highly participatory process led by the Population Welfare Department, Government of Sindh, under the leadership of the FP2030 SBC Sub-Group chaired by Dr. Talib Lashari, Technical Advisor and Focal Person FP2030, PWD Sindh.

### Guiding Principles for the SBC Strategy

The strategy and its presentation has been purposively designed around clear guiding principles to ensure it not only addresses foundational gaps but also sets a strong course for sustainable, high-quality SBC programming to support the achievement of FP2030 objectives. These principles inform all aspects of the strategy, from technical design to implementation, financing, and adaptation.

- ▼ **Provide a Comprehensive Technical Resource for SBC in Sindh:** SBC strategy has been conceptualized to serve as a technical resource capable of serving as input material to guide the co-creation of operational plans.
- ▼ **Build a Strong, Theory-Informed Technical Foundation:** The strategy commits to embedding behavioral science and proven SBC methodologies to ensure interventions are rigorous, context-sensitive, and impactful.
- ▼ **Promote Dynamic, Adaptable, and Inclusive Approaches:** It is designed to encourage broad stakeholder participation, supporting co-creation and tailoring interventions to local needs as they evolve.
- ▼ **Advance Sustainable, Phased Planning and Financing:** By focusing on phased, costed implementation plans and identifying funding gaps early, the strategy positions SBC for longer-term investments and partnerships.
- ▼ **Leverage and Strengthen Existing Systems and Resources:** The strategy prioritizes using and enhancing current health and community platforms, drawing on past SBC lessons to promote low-cost, high-return approaches.

### Strategic Planning Framework

This strategy was guided by Green and Kreuter's PRECEDE-PROCEED Model, a globally recognized framework for designing, implementing, and evaluating health promotion programs. This model helped anchor the process on desired outcomes and worked backwards through underlying social, individual, and environmental determinants to identify practical, locally responsive interventions. It ensured that active participation by intended audiences and stakeholders remained central throughout, reflecting the principle that communities should define their priorities and shape their solutions. Section 2 provides an overview of the diagnosis and needs assessment which has informed the articulation of key priorities.

## Strategy Development Process

The strategy development process (Figure 4) included a robust review of existing quantitative data on health behaviors, desk reviews of global and national evidence, and detailed analysis of prior SBC records and action plans from Sindh. Building on foundational resources from 2020 to 2024, including the COVID-19 SBC campaign for postpartum family planning, the rapid landscape assessment for SBC, and the PWD Male and Media Engagement Strategies, this effort consolidated diverse learnings into a unified approach tailored for Sindh. These earlier initiatives provided crucial insights on behavioral barriers, community dynamics, and effective communication channels, laying the groundwork for a comprehensive, province-wide SBC framework.

This was complemented by multiple layers of stakeholder consultations that brought together the Department of Health, Population Welfare Department, local and international NGOs, and donors. Over the past year, this inclusive process translated into a multistage consultative journey summarized in Figure 4.

**Figure 4: Methodology and Strategy Development Process**



In April 2024, initial consultations were held with key stakeholders to shape the scope and direction of the strategy. Draft 1 was presented in May 2024 in a meeting chaired by the Honorable Minister, generating detailed feedback on priority themes.

By August, Draft 2 was discussed, ensuring integration of issues like gender-based violence and youth engagement, and setting the stage for finalizing the implementation plan. Draft 3 was reviewed in January 2025 in a virtual session with government officials and partners. This led to the final milestone on May 13, 2025, when the strategy was presented at a high-level review meeting chaired by the Honorable Minister for Health and Population Welfare as an internal launch for validation and endorsement.

This rigorous, iterative approach reflects a shared commitment across the province to an SBC strategy that is grounded in evidence, inclusive of diverse perspectives, and focused on long term impact. The strategy is designed not just as a static document but as a technical resource to guide co creation of operational plans tailored to the unique needs of each district, to be complemented by future planning, implementation, and evaluation efforts led by local actors.

## Assessment of Needs

A comprehensive analysis of the socio-demographic, behavioral, service delivery, and policy landscape in Sindh highlights deep-rooted barriers to family planning and reproductive health, alongside emerging opportunities to catalyze change.

This comprehensive needs assessment, presented in Annex 1, has shaped the identification of critical needs that must be addressed to drive meaningful, sustained improvements in FP/MNCH behaviors in Sindh through the SBC Strategy.

## Priority Audiences and Audience Segments

The strategy must focus on unmarried adolescents and youth with low information-seeking and service utilization for SRH needs; married women of reproductive age (MWRA) and married men who lack birth planning, delay or avoid contraceptive use, underutilize skilled care, and do not practice PFP; husbands who withhold financial support or discourage spousal health-seeking; mothers-in-law who resist shared decision-making and family planning; community influencers who show limited endorsement of key behaviors; healthcare providers whose biases compromise person-centered care; and decision-makers who under-prioritize SBC and FP/RMNCH stewardship.

## Priority Behaviors to Change for Audience Segments

As outlined, these include reducing early marriages; improving contraceptive use to prevent adolescent pregnancies, delay first births, and space subsequent births; increasing complete ANC/PNC visits and skilled facility births; promoting PFP; fostering husbands' financial support and spousal communication; enhancing mothers-in-law's support for family planning; strengthening community ownership of FP/RMNCH initiatives; and improving provider counseling, especially on PFP during ANC, birth, and PNC.

## Targeted Approaches for Users, Intenders, Non-Intenders, Youth, and Community Engagement

Support and counsel current users to ensure continued, satisfied care; link intenders to quality services and integrate FP systematically into routine healthcare encounters; engage non-intenders through multi-channel, multi-modal communication and non-communication interventions that build intention and shift norms; customize strategies to youth needs; and amplify youth and community-led mid-media and mass media platforms to foster dialogue, normalize healthy behaviors, and increase social salience.

## Invest in Social and Gender Norm Change through Community and Mass Media

Expand community and mass media initiatives to elevate supportive norms and gender equitable attitudes, including by raising awareness of existing legislation on reproductive rights among a wide range of opinion leaders, influencers, and community networks to reinforce enabling environments for FP/RMNCH.

### System and Supply Side Areas of Support

Priorities include structurally integrating FP in MNCH services to leverage high contact points; enhancing training, capacity building, and supervision of public and private providers; mobilizing the private sector, especially for digital and youth-responsive services; institutionalizing provider behavior change initiatives; heavily investing in PPFPP as a proven high-impact practice; and strengthening data systems to better track and use service delivery data for continuous improvement.

### Strengthen Stewardship and Coordination for SBC Integration

Bolster the FP2030 Working Group as a key provincial platform to lead SBC integration into FP and MNCH efforts and actively mobilize diverse stakeholders in participatory prioritization and joint action planning to achieve common goals that advance family planning and reproductive health outcomes.

## Audience Analysis

A specific understanding of the diverse groups who shape or directly practice FP and RMNCH behaviors in Sindh is essential for designing effective SBC interventions. This strategy applies insights from the preceding analysis to categorize and analyze the audiences that must adopt, influence, or enable key behaviors. By doing so, it ensures that SBC efforts address knowledge gaps, social norms, policy constraints, and broader community dynamics simultaneously.

The analysis identifies three major categories of audiences:

- 1. Primary Audiences (Doers):** Individuals whose behaviors must change for better FP/RMNCH outcomes. They include married women, adolescent girls, new mothers, and fathers who play a direct role in adopting and practicing the target behaviors.
- 2. Secondary Audiences (Key Influencers):** Those who exert a direct impact on the decisions and practices of the primary audiences. Mothers-in-law, community elders, peers, and religious leaders often dictate norms around birth spacing, child marriage, and family health choices.
- 3. Tertiary Audiences (Enabling Environment):** Actors who indirectly shape individual and household behaviors through policy, service delivery, information dissemination, or resource allocation. These include policymakers, district health managers, healthcare providers, donors, private-sector partners, and media outlets.

By mapping the audiences at these different tiers and understanding the behavioral barriers and motivators that affect each group, the strategy can develop targeted interventions that foster positive change at every level, from laws and budgets to interpersonal relationships and household decision-making.

## Primary Audiences (Doers)

### Married Women of Reproductive Age (MWRA)

Married women (ages 15–49) in both rural and urban Sindh are the principal decision-makers, or potential decision-makers, for contraceptive adoption, antenatal care (ANC), safe delivery, postpartum care, exclusive breastfeeding, and child immunization. Yet, many face formidable obstacles, including limited autonomy, fear of contraceptive side effects, social misconceptions, and lack of spousal or household support.

Recent data (e.g., PDHS 2017–18) indicate a modern contraceptive prevalence rate hovering around 24%, with rural rates even lower. Fewer than 40% of women recall relevant FP messages, signaling the urgent need for informed and sustained engagement.

### Adolescent Girls (Married and Unmarried)

Adolescent girls, especially those in rural areas, often encounter early marriage, limited reproductive health knowledge, and constrained decision-making power. Nearly 9.9% of girls in Sindh start childbearing by age 18, highlighting the risks of teenage pregnancy.

### Expectant and New Mothers

Expectant mothers and women who have recently given birth play central roles in shaping RMNCH outcomes, yet they frequently lack comprehensive support or accessible services. Barely 56.4% of new mothers in Sindh receive postnatal care, leaving gaps in breastfeeding initiation, PFP, and immunization uptake.

### Fathers and Husbands (Men of Reproductive Age)

Men often control finances and make or veto decisions about FP or healthcare. Traditional notions of masculinity and pervasive myths about contraceptive methods can hinder men's involvement in RMNCH. PDHS findings suggest that approximately 87% of couples report "joint decisions" on contraceptive use, yet deeper analysis reveals that male opinions routinely override women's.

## Secondary Audiences (Key Influencers)

### Mothers-in-Law and Other Elder Family Members

In extended households, older women (or male elders) maintain considerable authority over FP decisions and postpartum care. Their convictions regarding immediate childbearing or frequent births can undermine women's autonomy.

**Table 1: Priority Audiences and Family Planning Behaviors to Change**

Level	Audience	Behaviors to change
INDIVIDUAL	Unmarried adolescents and Youth	<ul style="list-style-type: none"> <li>• Poor information seeking behaviors for family planning</li> <li>• Lack of service utilization for adolescent and youth sexual and reproductive health needs</li> <li>• Early marriages</li> </ul>
	Married women of reproductive age (MWRA) and Married Men	<ul style="list-style-type: none"> <li>• Lack of birth planning</li> <li>• Lack of contraceptive use to prevent adolescent pregnancies</li> <li>• Low modern contraceptive use to delay first birth</li> <li>• Low modern contraceptive use for birth spacing</li> <li>• Lack of complete ANC and PNC visits</li> <li>• Sub-optimal use of skilled birthing care and facility births</li> <li>• Low use of post-pregnancy family planning</li> </ul>
HOUSEHOLDS	Husbands	<ul style="list-style-type: none"> <li>• Lack of favorable disposition towards family planning</li> <li>• Lack of financial support</li> <li>• Lack of inter-spousal communication</li> <li>• Mistrust towards spouses</li> <li>• Refusal to accompany spouses to healthcare facilities,</li> <li>• Lack of encouragement for wives towards health-seeking behaviors.</li> </ul>
	Mothers-in-law	<ul style="list-style-type: none"> <li>• Opposition to shared decision-making and family planning.</li> <li>• Lack of support for interspousal communication</li> </ul>
COMMUNITY	Religious leaders, Community leaders, community activities, and peers	<ul style="list-style-type: none"> <li>• Lack of adequate engagement and involvement in key health issues at the community level</li> <li>• Low levels of endorsement by community influencers for key health behaviors and initiatives</li> <li>• Lack of community ownership of initiatives.</li> </ul>
SERVICE DELIVERY	Facility and community-based health care providers	<ul style="list-style-type: none"> <li>• Provider bias and poor clinical and behavioral competence for delivering gender and youth sensitive, person-centered care and services.</li> <li>• Counsel women on PFP during ANC, at the time of birth, and during PNC.</li> </ul>
INSTITUTIONAL & POLICY	Decision makers and Influencers	<ul style="list-style-type: none"> <li>• Lack of prioritization of stewardship for SBC to promote adoption of family planning and reproductive health care services</li> </ul>

## Community Opinion Leaders

Imams, tribal elders, and local notables significantly influence communal attitudes on early marriage, large families, and postpartum care. Other informal influencers, teachers, mentors, youth club leaders, often shape adolescent perspectives on reproductive health or early marriage.

## Healthcare Providers (Facility and Community Level)

A wide range of professionals, Lady Health Workers, midwives, immunization staff, doctors, regularly interact with women and families. They can either facilitate or inadvertently hinder postpartum FP uptake, immunizations, or skilled deliveries, depending on their counseling approach or biases.

## Tertiary Audiences (Enabling Environment)

### Policymakers and Provincial Leadership

Policy-level actors, including Sindh's lawmakers, department secretaries, and district commissioners, frame the legal, budgetary, and administrative conditions under which families make RMNCH decisions.

### Media Outlets, Civil Society Organizations, and Social Media Influencers

Media campaigns or digital platforms can echo, distort, or amplify RMNCH messages. CSOs and activists also shape public opinion and mobilize communities.

### Donors, Private Sector, and Philanthropic Entities

Donor agencies, corporate sponsors, or philanthropic organizations often fund large-scale interventions and can influence project scope and messaging.

## Prioritizing Behaviors and Audiences by District and Demographic

While the above behaviors and audience roles apply across Sindh, contextual variations exist between urban and rural districts, and among different socio-economic or religious communities. The strategy proposes district-level assessments and baseline metrics to pinpoint the most pressing needs, such as high child marriage rates in particular rural belts or lower immunization coverage in certain peri-urban zones. These local insights will guide how best to allocate resources, sequence interventions, and adapt approaches to each audience group's constraints and cultural norms.

## Linking Audiences to Priority Behaviors and Strategy

Each of the priority behaviors described previously rely on one or more of these audience segments. married women, adolescent girls, or new mothers must adopt healthier practices (the doers).

Mothers-in-law, imams, or health workers must shift attitudes and interactions to influence these women more positively (the key influencers). Meanwhile, policymakers, donors, or private-sector players must develop budgets, pass regulations, or provide stable supply lines to ensure that adoption and continuation of RMNCH behaviors are both feasible and sustainable (the enablers).

**Annex 2 presents the Audience Analysis Matrix** which provides an overview of how the strategy's SBC interventions align with the unique motivations and barriers that each audience group faces, ensuring integration rather than fragmentation.

# Sindh SBC Strategy for FP/RMNCH



## Section 3: Sindh SBC Strategy for FP/RMNCH

This Sindh SBC Strategy for FP/RMNCH takes its starting inspiration from the mission statement of Department of Health Sindh. The overall vision is based on Sindh Health Policy “Health for All” which aims to “protect people against hazardous diseases, promote public health, upgrade curative health facilities, and enhance equity, efficiency and effectiveness in health sector.” Based on this, the vision, goal, key strategies, and priority outcomes (strategic objectives) of the SBC strategy are outlined below:

### Vision

By 2030, Sindh becomes a national leader in achieving essential RMNCH and FP outcomes, significantly reducing infant and maternal mortality through birth spacing and uptake of contraceptives in alignment with Pakistan's commitments to the United Nations Sustainable Development Goals (SDGs).

### Goal

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

### Key Strategies and Outcomes

The SBC Strategy Framework for Sindh consists of three interlinked strategies informed by the change theory-guided behavior change pathways for each level that are presented in the technical approach (please see Figure 5 below and Annex 3).

**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/RMNCH information, services, and interventions, the increased adoption of male family planning methods.

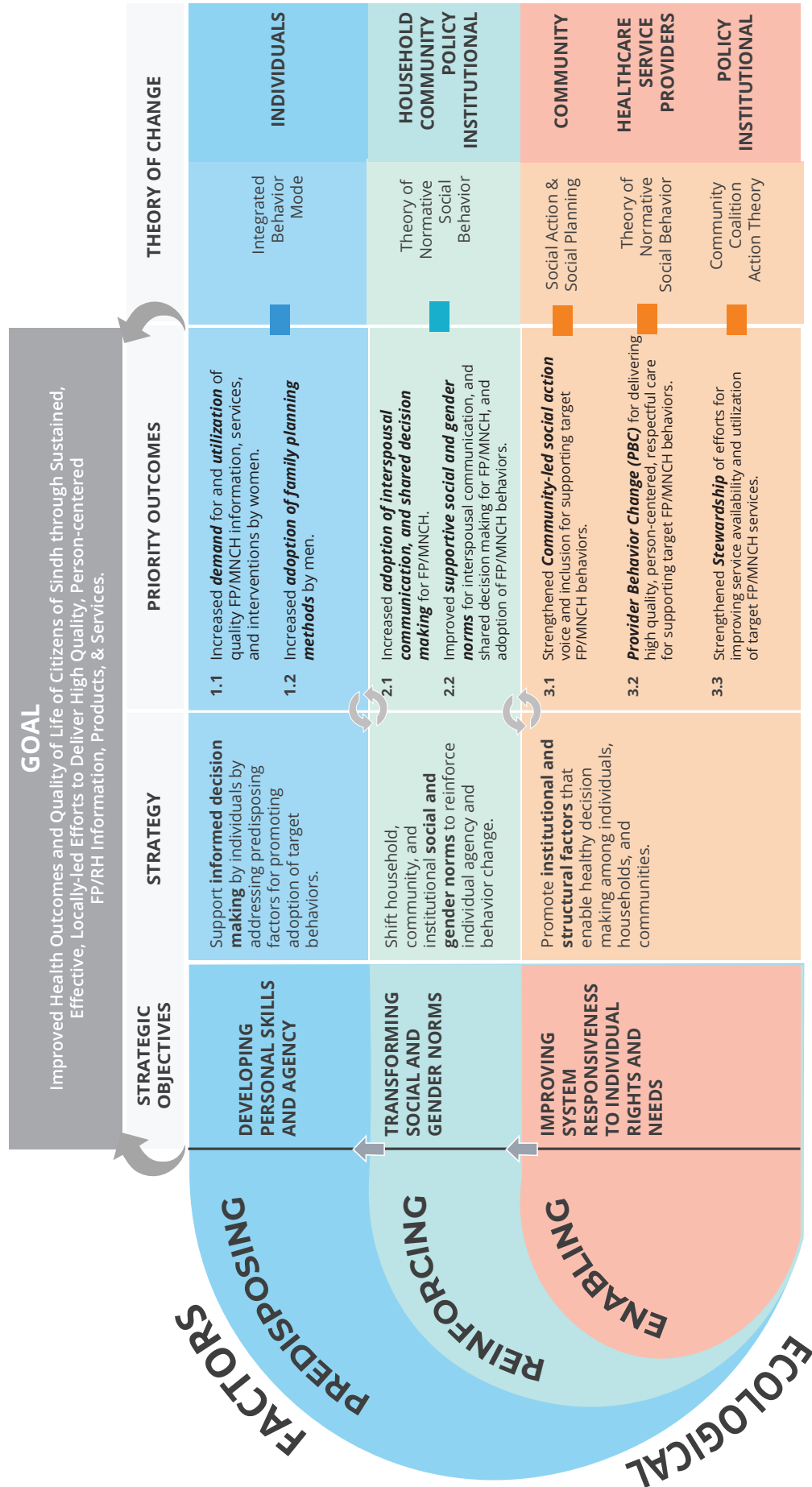
This strategy endeavors to assist individuals in developing intentions for health-promoting FP/RMNCH behaviors by refining attitudes, strengthening personal agency, and reshaping perceptions of social and gender norms

#### **STRATEGY 1 SUPPORT INFORMED DECISION MAKING BY INDIVIDUALS BY ADDRESSING PRE- DISPOSING FACTORS FOR PROMOTING ADOPTION OF TARGET BEHAVIORS.**

##### **Strategy Outcomes**

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

Figure 5: Sindh SBC Strategy Framework and Technical Approach



associated with these behaviors. To aid individuals in transitioning from intention to action, SBC interventions will prioritize enhancing individual knowledge and skills, mitigating environmental constraints, and emphasizing the importance of health-promoting FP/RMNCH 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.

**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/RMNCH and advocating for supportive social and gender norms conducive to FP/RMNCH 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/RMNCH, 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/RMNCH 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 high-quality,

### **STRATEGY 2 SHIFT HOUSEHOLD, COMMUNITY, AND INSTITUTIONAL SOCIAL AND GENDER NORMS TO IMPROVE MALE ENGAGE- MENT AND REINFORCE INDIVIDUAL AGENCY AND BEHAVIOR CHANGE.**

#### **Strategy Outcomes**

- 2.1. Increased adoption of interspousal communication, and shared decision making for FP/RMNCH
- 2.2. Improved supportive social and gender norms for interspousal communication, shared decision making for FP/RMNCH, and adoption of FP/RMNCH 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 FP/RMNCH behaviors.
- 3.2. Provider Behavior Change (PBC) for delivering high quality, person-centered, respectful care for supporting FP/RMNCH behaviors.
- 3.3. Strengthened Stewardship of efforts for improving service availability and utilization of FP/RMNCH services.

person-centered care, and enhancing stewardship efforts to improve the availability and utilization of FP/RMNCH services.

By improving system responsiveness to individual rights and needs, the strategy aims to streamline access to and utilization of FP/RMNCH 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/RMNCH 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.

## Technical Approach

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 5) 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.

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).
- ▼ For shifting social and gender norms at all levels objectives are informed by the Theory of Normative Social Behavior (TNSB).
- ▼ At the level of the community, engagement objectives are informed by the Social Planning and Social Action Model (SAPM) of community building.
- ▼ 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).

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.

For a detailed overview of the theoretical underpinning including theory of change and SBC engagement and communication objectives, please see **Annex 3**.

# Strategy 1



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

### Strategy 1.1: Increased adoption of FP/RMNCH behaviors by women

#### Audience and Target Behaviors

PRIMARY AUDIENCE	WOMEN OF REPRODUCTIVE AGE (15 – 49 YEARS)
AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
UNMARRIED YOUTH (15-29 YEARS)	<ul style="list-style-type: none"> <li>Seek age and life stage appropriate information for family planning</li> <li>Utilize age and life stage appropriate sexual and reproductive health services</li> </ul>
NEWLY MARRIED WOMEN	<ul style="list-style-type: none"> <li>Adopt modern family planning methods from local health facility, for delaying pregnancy / preventing unplanned pregnancy</li> </ul>
MARRIED PREGNANT WOMEN	<ul style="list-style-type: none"> <li>Utilize skilled, integrated FP/RH care to complete Key FP/RH Behaviors:               <ol style="list-style-type: none"> <li>4 Antenatal care (ANC) visits</li> <li>Facility-based birth</li> <li>Timely Postnatal Care (PNC) visit</li> <li>Adopt post-partum family planning method</li> <li>Adopt post-abortion family planning method</li> </ol> </li> </ul>
MARRIED WOMEN WITH CHILDREN	<ul style="list-style-type: none"> <li>Adopt modern family planning method from local health facility, for delaying pregnancy / preventing unplanned pregnancy</li> </ul>

#### Communication & Engagement Objectives

- I. **Build Intention:** Young women and MWRA develop expectations and intention to adopt skilled, integrated FP/RMNCH care for completing target behaviors.
  - a. **Improved Attitude:**
    - i. Young women and MWRA feel comfortable about utilizing skilled, integrated FP/RMNCH care for completing target behavior.

- ii. Young women and MWRA believe utilizing skilled, integrated FP/RMNCH 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/RMNCH care for completing target behavior.
- ii. Young women and MWRA believe that her husband will support her in utilizing skilled, integrated FP/RMNCH 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/RMNCH 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 of target behaviors by intending MWRA**

**a. Improved Knowledge and Skills:**

Young women and MWRA have correct knowledge and skills for accessing FP/RMNCH 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

S/No	Channel	Planned Interventions / Activities
<b>I Interventions for Building Intention</b>		
1.	<b>Married women of reproductive age (MWRA) and Married Men</b>	<ul style="list-style-type: none"> <li>Household visits with IPC using PRA tools (photos, timelines, daily routines), Sehat Ki Dastak toolkit, referrals</li> <li>Small group community meetings, social mapping, peer role models, to build norms (e.g., PFPF, PAFP)</li> <li>Women's community seminars led by health staff and local leaders to discuss RH/FP, share experiences, debunk myths</li> <li>Community theatre led by women for women, focusing on overcoming barriers and inspiring uptake</li> </ul>
2.	<b>Community signposting</b>	<ul style="list-style-type: none"> <li>Public signboards in busy community spaces highlighting dangers of poor FP/RMNCH practices, promoting key messages, government endorsement, and directing to services.</li> </ul>
3.	<b>Social media</b>	<ul style="list-style-type: none"> <li>Public Service Announcements (PSAs) on TV, print, radio, digital platforms featuring key messages and opinion leader testimonials</li> <li>Radio &amp; TV talk shows with experts and call-ins</li> <li>Human interest stories in popular magazines like Akhbar-i-Jahan, using storytelling for dramatic relief</li> <li>Animated videos addressing barriers and promoting behaviors.</li> </ul>
4.	<b>Mass media</b>	<ul style="list-style-type: none"> <li>Regular tailored content on Facebook, X, Instagram, Snapchat, TikTok, YouTube</li> <li>Virtual social networks managed by champions (WhatsApp, Telegram, Signal) to cascade messages within local family/friends groups</li> <li>TikTok star and influencer campaigns: short reels, challenges, content aligned with international health days.</li> </ul>
5.	<b>SMS-based campaigns</b>	<ul style="list-style-type: none"> <li>Thematic SMS campaigns (daily messages over 60 days before key health days), tailored for women, men, and household influencers</li> <li>Pilot an mHealth SMS/voice intervention to promote PFPF and skilled birth care, testing cost-effective models vs. personal counseling</li> </ul>

S/No	Channel	Planned Interventions / Activities
<b>II Interventions for facilitating adoption and sustained use</b>		
6.	<b>Increasing Knowledge and Skills</b>	
a	<b>Youth-focused education &amp; engagement</b>	<ul style="list-style-type: none"> <li>• LSBE integration into school curricula</li> <li>• Marital counseling via nikah registrars for young couples</li> <li>• Partnerships with universities for seminars, conferences, sports events with key FP/RMNCH messaging</li> <li>• University lectures and branding at sports events to reach young women</li> </ul>
b	<b>MWRA's knowledge and skills through SBCC</b>	<ul style="list-style-type: none"> <li>• All existing channels indicated above will integrate knowledge and skills messages</li> </ul>
7.	<b>Improving access to care and reduced environmental constraints</b>	
a	<b>Community-based outreach</b>	<ul style="list-style-type: none"> <li>• Deployment of private CHWs in LHW-uncovered areas linked to social marketing/franchising</li> <li>• Community volunteers assist FWWs, FWAs, LHWs, private CHWs in organizing demand generation and small events.</li> <li>• Community outreach camps jointly with partners.</li> </ul>
b	<b>Facility-based interventions</b>	<ul style="list-style-type: none"> <li>• Structural integration of FP, especially PFP, into routine MNCH services (DoH, PPHI Sindh, pilot in TAY)</li> <li>• Tailored counseling at facilities linked to provider behavior change</li> <li>• Couples counseling integrated into antenatal services, with gynecologist training</li> <li>• Enhanced private sector involvement via social franchising, vouchers for BISP families, and referral systems tied to SBC activities</li> </ul>
c	<b>Digitally linked services for youth &amp; private care</b>	<ul style="list-style-type: none"> <li>• Explore social marketing tied to networks like BOLO Health Digital Marketplace, with short-term methods for youth who can pay, leveraging scalable digital solutions</li> </ul>

## I. Strategies for Building Intention among Women

### 1. FIELD WORKER-LED 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:

- a. **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.
- b. **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 PFPF and PAFP.
- c. **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.
- d. **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. PWD will collaborate with development partners to develop and advance the role of community theater in supporting dissemination of key messages on FP/RMNCH. Following collaborative action planning with development partners, PWD will facilitate and steward women-led community theatre in urban and rural areas across Sindh. 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/RMNCH 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.

## 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/RMNCH 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/RMNCH.



### Key Activities

**i. Provincial Signposting Approach:** PWD will steward the development of community signposting strategy in collaboration with other departments (e.g., DoH, 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.

**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.

## 3. MASS MEDIA

SBC through mass media will include all available channels, including print, television, and radio and will be undertaken in collaboration with PWD and DOH. Interventions described below are designed to be complementary and additive to activities described in the **PWD Sindh Media Engagement Strategy for Family Planning 2024** which aim to establish meaningful partnerships with media stakeholders to incorporate targeted, data-driven, salient family planning themes across different media channels. Please refer to the Media Engagement Strategy document for details on activities summarized in the text box.

## SINDH MEDIA ENGAGEMENT STRATEGY FOR FAMILY PLANNING PWD, GOS – KEY ACTIVITIES

- ▼ Establishment of PWD Media Forum
- ▼ Stakeholder mapping and Formative review of media perspectives, needs, and content Capacity Building Workshops for media stakeholders.
- ▼ Media Dialogue events
- ▼ Media Stakeholder Exposure Visits
- ▼ Media Fellowships to develop policy pieces and human-interest stories
- ▼ Media Partnerships (Print, TV, Radio, social media) for inclusion of key themes and messages in productions and airing PWD PSAs
- ▼ Media Award Events

Key interventional approaches for reaching women through mass media will include:

- a. **Public Service Announcements (PSAs).** PWD will organize and distribute the vast repository of video messaging already available and complement 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.
- ii. **Radio and 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.
- iii. **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.

- d. **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.



### Key Activities

i. **Development of a FP/RMNCH 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/RMNCH 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/RMNCH 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.

## 4. SOCIAL MEDIA

PWD's social media strategy is designed to leverage partnerships developed with social media stakeholders. Please see PWD's Sindh Media Engagement Strategy 2024 for activities. PWD will undertake to engage and mobilize social media stakeholders.

Social media 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.

- a. **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.
- b. **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.
- c. **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).
  - i. **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/RMNCH. 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/RMNCH Campaign design, content from other channels, and provides linkages with formal information sources.
  - ii. **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/RMNCH 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 Sindh. 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.

## 5. SMS-BASED CAIMPAIGN

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 Sindh 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.

- a. Targeted SMS Campaigns:** 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.
- b. Pilot testing of a theory-driven mHealth intervention for PpFP:** PWD will explore the feasibility for adaptation and testing of an existing SMS-based mHealth intervention aimed at promoting the adoption of skilled birthing care and PpFP. Building upon existing evidence-based interventions, this initiative will involve assessing the feasibility and effectiveness of leveraging SMS communication to drive positive health behaviors related to maternal and child health. The intervention involves a randomized controlled trial utilizing non-smartphone, SMS-based, structured messaging, including in-person counseling, voice and text messages, or interactive telephone counseling, to enhance maternal health and contraception awareness among pregnant women in target areas. Developed based on the Integrated Behavior Model, the intervention and its protocol are readily available for adaptation and is aimed at improving contraceptive utilization and healthcare utilization indicators such as antenatal visits, institutional delivery, postnatal care, and breastfeeding rates. The study will specifically explore whether the text and voice messages approach prove to be non-inferior to personal counseling and interactive calls, and if so, it could offer evidence to support scale-up of a cost-effective means of healthcare promotion for FP/RMNCH behaviors.



## Key Activities

**i. Establishment of Research Team in Collaboration with DoH and Partners:** PWD will collaborate with DoH and development partners to establish a research team comprising healthcare professionals, researchers, and community representatives. This team will be responsible for overseeing the planning, execution, and monitoring of the mHealth intervention study.

**ii. Adaptation of the Intervention and Development of Study Protocol:** PWD in partnership with its research team and relevant stakeholders, will adapt the existing SMS-based mHealth intervention and study protocol to suit the local context and target population. This adaptation process will ensure cultural relevance, linguistic appropriateness, and alignment with national health priorities. The protocol will include a detailed description of a formative phase for development, testing, validation, and agreement on PpFP SMS Messages.

**iii. Ethical Approval for the Study:** PWD will seek ethical approval from relevant institutional review boards and regulatory bodies to ensure the study adheres to ethical principles and guidelines. This process involves submitting detailed study protocols, informed consent forms, and other relevant documentation for review and approval.

**iv. Study Implementation in Target Areas:** Following ethical approval, PWD will oversee the initiation of implementation of the mHealth intervention study in the target areas. This involves recruiting participants, delivering the intervention, collecting data, and monitoring the progress of the study.

## II. Strategies for facilitating adoption and maintenance of behaviors among women

### 6. STRATEGIES FOR IMPROVED KNOWLEDGE AND SKILLS AMONG INDIVIDUALS

**a. Improved knowledge and skills among Female Adolescents and Youth in Sindh:** Strategies for engaging female youth at universities in Sindh 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.

**i. Life Skills-based Education (LSBE):** Support sustainable integration of LSBE into private and public-school curricula in the province of Sindh following the government decision in 2018 to include LSBE in the school curriculum. This will be guided by Curriculum Guidelines for Life Skills Based Education - Adapted from 'It's All One Curriculum, notified by the Education & Literacy Department, GoS and supported by the PWD Sub-group on Adolescent and Youth Engagement.

**ii. Marital Counseling program:** As part of the effort to provide targeted educational interventions, and under the aegis of the PWD, a robust program of 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 governments, and relevant GoS departments, e.g. WDD, Community Development Department, Higher Education Department, etc. 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 PFP, 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.

**iii. Establishing University Partnerships:** As a critical step in this plan, partnerships will be established with public and private sector universities, including prominent institutions. 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.

**iv. 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 partnered universities and will include popular sports for female youth. 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.

**v. 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.

**b. 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.

## 7. STRATEGIES FOR REDUCING ENVIRONMENTAL CONSTRAINTS AND IMPROVING SERVICE AVAILABILITY

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

**i. 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.

**ii. 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 FWAs, FWWs, 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.

**iii. 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. Digital innovations, e.g. the Sehat Saheli app prototype will be explored for e-learning approaches.

**iv. 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.

### b. Improved availability of family planning services through facility-based providers

**i. Structural Integration of family planning and PpFP in DoH and PPHI Sindh facilities:**

As Sindh embarks on its ambitious journey towards ensuring Universal Health Coverage (UHC) through full implementation of over 90 priority interventions as part of the Sindh Essential Package of Health Services (EPHS). These include family planning and PpFP and this integration is being piloted in District Tando Allah Yar under the supervision of the EPHS Steering Committee and guided by the visionary leadership of the Honorable Minister for Health and Population Welfare, Dr. Azra Fazal Pechuho as Chair. Supported by the Aga Khan University and the Bill and Melinda Gates Foundation, this pilot aims to fully integrate family planning in health services across all public sector service delivery platforms and includes a robust plan for meaningful community engagement. PWD will actively collaborate with the district team through its DPW office to ensure integration and linkages across DoH and PWD during this phase. PWD will also serve to rally development partners in support of this pilot intervention and contribute to the development of the institutionalization and scale up plan.

**ii. 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 for a description of the intervention focusing on PpFP and youth-friendly services.

**iii. Enhancing Couples Counseling and PpFP services 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 high quality family planning counseling during antenatal care for couples 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.

**iv. 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 supported through development partners in areas not covered by the LHW program. Social Marketing linked with fractional clinical franchising will be adapted for priority districts with high need. These will be linked to and support private sector CHWs described earlier.

**v. 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. Funding and financing modalities will be identified through development partner and donor support.

**vi. 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 made to develop 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 family planning will be leveraged to complement PWD investments.

**c. Improved availability of family planning services through digitally linked private sector service providers**

PWD will collaborate with development partners to 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 youth-led BOLO Health Digital Youth Marketplace for Family Planning, operated by Oladoc and inaugurated by the Honourable Minister for Health and Population Welfare, GoS in 2024.

## 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)	<ul style="list-style-type: none"> <li>Seek age and life stage appropriate information for family planning</li> <li>Utilize age and life stage appropriate sexual and reproductive health services</li> </ul>
NEWLY MARRIED WOMEN	<ul style="list-style-type: none"> <li>Adopt a male method for family planning (withdrawal or condoms) for delaying first pregnancy / preventing unplanned pregnancy.</li> </ul>
EXPECTING HUSBANDS AND FATHERS	<ul style="list-style-type: none"> <li>Adopt male method for family planning (withdrawal or condoms) post-partum for preventing unplanned pregnancy and delaying next pregnancy.</li> </ul>
FATHERS WHO WANT MORE CHILDREN	<ul style="list-style-type: none"> <li>Adopt male method for family planning (withdrawal or condoms) for preventing unplanned pregnancy and delaying next pregnancy.</li> </ul>
MEN WHO HAVE COMPLETED THEIR FAMILIES AND WANT NO MORE CHILDREN	<ul style="list-style-type: none"> <li>Adopt male sterilization (non-surgical vasectomy) for preventing unintended pregnancy.</li> </ul>

### 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:**

Young women and MWRA have correct knowledge and skills for accessing FP/RMNCH 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

S/No	Channel	Planned Interventions / Activities
<b>I Interventions for Building Intention</b>		
1.	<b>Field worker-led community-based health education</b>	<ul style="list-style-type: none"> <li>• Male community meetings with IPC using PRA tools (photos, timelines, daily routines), Sehat Ki Dastak toolkit, referrals</li> <li>• Husband Community Forum for small group community meetings with married men focusing on training and reinforcing the knowledge and importance of promoting and using family planning services</li> <li>• Community theatre focusing on delivering information, encouraging action, overcoming barriers and inspiring uptake.</li> </ul>
2.	<b>Community signposting</b>	<ul style="list-style-type: none"> <li>• Public signboards in busy community spaces highlighting dangers of poor FP/RMNCH practices, promoting key messages, government endorsement, and directing to services.</li> </ul>
3.	<b>Mass media</b>	<ul style="list-style-type: none"> <li>• Public Service Announcements (PSAs) on TV, print, radio, digital platforms featuring key messages and opinion leader testimonials.</li> <li>• Radio &amp; TV talk shows with experts and call-ins</li> <li>• Human interest stories in popular magazines like Akhbar-i-Jahan, using storytelling for dramatic relief.</li> <li>• Animated videos addressing barriers and promoting behaviors.</li> </ul>
4.	<b>Social media</b>	<ul style="list-style-type: none"> <li>• Regular tailored content on Facebook, X, Instagram, Snapchat, TikTok, YouTube</li> <li>• Virtual social networks managed by champions (WhatsApp, Telegram, Signal) to cascade messages within local family/friends groups</li> <li>• TikTok star and influencer campaigns: short reels, challenges, content aligned with international health days.</li> </ul>
5.	<b>SMS-based campaigns</b>	<ul style="list-style-type: none"> <li>• Thematic SMS campaigns (daily messages over 60 days before key health days), tailored for men as users.</li> </ul>

S/No	Channel	Planned Interventions / Activities
<b>II Interventions for facilitating adoption and sustained use</b>		
6.	<b>Increasing Knowledge and Skills</b>	
a	<b>Youth-focused education &amp; engagement</b>	<ul style="list-style-type: none"> <li>• LSBE integration into school curricula</li> <li>• Marital counseling via nikah registrars for young couples</li> <li>• Partnerships with universities for seminars, conferences, sports events with key FP/RMNCH messaging</li> <li>• University lectures and branding at sports events to reach young women</li> </ul>
b	<b>MWRA's knowledge and skills through SBCC</b>	<ul style="list-style-type: none"> <li>• All existing channels indicated above will integrate knowledge and skills messages</li> </ul>
7.	<b>Improving access to care and reduced environmental constraints</b>	
a	<b>Community-based outreach</b>	<ul style="list-style-type: none"> <li>• Revitalization of Sindh Male Mobilizer Program</li> <li>• Strengthening PWD Family Welfare Cadres through training and support</li> <li>• Male community volunteers assist FWWs, FWAs, LHWs, private CHWs in organizing demand generation and small events.</li> <li>• Community outreach camps jointly with partners.</li> </ul>
b	<b>Facility-based interventions</b>	<ul style="list-style-type: none"> <li>• Structural integration of FP, especially PFP, into routine MNCH services (DoH, PPHI Sindh, pilot in TAY)</li> <li>• Tailored counseling at facilities linked to provider behavior change</li> <li>• Couples counseling integrated into antenatal services, with gynecologist training</li> <li>• Enhanced private sector involvement via social franchising, vouchers for BISP families, and referral systems tied to SBC activities</li> </ul>
c	<b>Digitally linked services for youth &amp; private care</b>	<ul style="list-style-type: none"> <li>• Explore social marketing tied to networks like BOLO Health Digital Marketplace, with short-term methods for youth who can pay, leveraging scalable digital solutions</li> </ul>

## I. Strategies for Building Intention among Men

### 1. MALE FIELD WORKER-LED 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:

- a. **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.
- b. **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.
- c. **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. PWD will collaborate with development partners to develop and advance the role of community theater in supporting dissemination of key messages on FP/RMNCH. Following collaborative action planning with development partners, PWD will facilitate and steward men’s community theatre in urban and rural areas across Sindh. These live productions will attempt to tackle prevalent obstacles and inspire the uptake of family planning methods by men.



## 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.

## 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.

## 3. 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.

#### 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.

#### 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, content, and protocol developed specifically for men.

## II. Strategies for facilitating adoption and maintenance of family planning use among men

### 6. STRATEGIES FOR IMPROVED KNOWLEDGE AND SKILLS AMONG INDIVIDUALS

#### a. Improved knowledge and skills among Adolescents and Youth

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

#### b. 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.

### 7. REDUCING ENVIRONMENTAL CONSTRAINTS FOR MEN TO ACCESS FP

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

**i. Revitalization of Male Mobilizer Program:** PWD Male Mobilizers program will be revitalized through review and prioritization of key investments in the program guided by recommendations described in the “Strategy for Revitalization of Male Mobilizers in PWD Sindh” developed by PWD with support from JHPEIGO. Key inputs needed will be discussed during the activity roadmap exercise. Activities may include expanded deployment of male mobilizers through development sector support in uncovered areas, development of Male Mobilizer job aids, training, and capacity development through master trainers for

step-down cascade trainings, introducing supportive supervision mechanisms for male mobilizers, improving collaborative synergies with the LHW program, and strengthened referral and data reporting mechanisms.

**ii. Strengthening PWD Family Welfare Cadres:** Using a similar approach, the plan involves strengthening the PWD Family Welfare Assistants (FWAs) through various measures. This includes developing male engagement job aids specifically designed for FWA, organizing training sessions facilitated by master trainers for cascading knowledge, implementing supportive supervision methods, fostering closer collaboration with the Male Mobilizer program, LHW program, Male Health Volunteers, and enhancing referral and data reporting systems.

**iii. 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.

**iv. Training and Empowering FWWs, FWs, Male Mobilizers, 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.

**v. 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.

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

**i. 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.

**ii. Strengthen, support, and expand facility-based delivery of male FP information, products, and services:** In collaboration with development partners, professional associations, and SMOs, male general practitioners and family physicians in Sindh will be trained on delivering male contraceptive information, products, services, and referrals. Male Counseling Corners and Couples' Counseling Corners will be strengthened at public sector facilities. PWD will also collaborate with professional associations and SMOs, to train and equip family physicians, male general practitioners, and other male focused specialties to provide family planning counseling inclusive of male contraceptive methods and referrals. Please see Strategy 1.1.

**iii. Urologist and Surgeon Training on NSV:** PWD will also explore training public and private sector urologists and surgeons in providing NSV services in Sindh. 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.

**iv. 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/RMNCH 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.

**v. 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.

**c. Improved availability of male family planning services through digitally linked service providers**

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

## Foundational Resources & IEC Materials for Delivering the Strategy

Supporting individual behavior change through diverse communication channels necessitates a meticulous approach in providing tailored materials and content (Table 2). 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.

**Table 2: Materials and Content needed for different channels for supporting Strategy 1.**

S. No.	CHANNELS	MATERIALS
1	Fieldworker-led SBC in individual and group settings	<ul style="list-style-type: none"> <li>SOPs, PRA tools, guides, and scripts for activities</li> <li>IEC materials by thematic area in local language</li> <li>Referral slips</li> </ul>
2	Service provider	<ul style="list-style-type: none"> <li>Service provider job-aids by thematic area</li> </ul>
3	Community signposting	<ul style="list-style-type: none"> <li>Banners, Billboards, and Community signposting</li> <li>branded vehicles and signposting for facilities</li> </ul>
4	Local Cable Television	<ul style="list-style-type: none"> <li>Scripted Audio/Video PSAs</li> <li>Broadcast plan for Talk Shows</li> </ul>
5	Helpline	<ul style="list-style-type: none"> <li>Branded content and creative design or cobranding across all materials and themes</li> </ul>
6	Social media	<ul style="list-style-type: none"> <li>Social media strategy and content</li> <li>Activity SOP and plan for Virtual WhatsApp networks</li> <li>IEC content including AV</li> </ul>
7	SMS	<ul style="list-style-type: none"> <li>SMS messages set by theme and behaviors</li> <li>Annual SMS campaign plan</li> </ul>

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/RMNCH behavior within the target population.

## 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.

## Strategy 2



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

### Strategy 2.1. Increased adoption of interspousal communication, and shared decision making for FP/RMNCH

#### Household Audience and Target Behaviors

PRIMARY AUDIENCE	HOUSEHOLD INFLUENCERS
AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
HUSBANDS	<ul style="list-style-type: none"> <li>Engage in inter-spousal communication (ISC) for discussing health planning for the family.</li> <li>Support adoption and maintenance of key health-promoting behaviors related to FP/RMNCH</li> </ul>
MOTHERS-IN-LAW	<ul style="list-style-type: none"> <li>Encourage son to engage in inter-spousal communication (ISC) to discuss health planning for the family.</li> <li>Support adoption and maintenance of key health-promoting behaviors related to FP/RMNCH</li> </ul>

#### Household Communication & Engagement Objectives

- I. **Create Descriptive Norm:** Household influencers 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:** Household influencers believe that people important to them expect them to adopt the target behaviors.
  - b. **Improve Outcome Expectation:** Household influencers believe that the outcomes of adopting target behaviors have substantive benefits for self, others, and community at large.
  - c. **Strengthen Group Identity: Household influencers:**
    - Have high aspirations for their family.

- Develop shared values with role models.
- Believe that their values require that they support the target behavior.

## Strategy 2.2. Improved supportive social and gender norms for interspousal communication, shared decision making for FP/RMNCH, and adoption of FP/RMNCH behaviors.

### Community Audience and Target Behaviors

PRIMARY AUDIENCE	COMMUNITY POPULAR OPINION LEADERS (CPOLs)
AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
<b>COMMUNITY ELDERS AND INFLUENCERS</b> <ul style="list-style-type: none"> <li>• RELIGIOUS SCHOLARS</li> <li>• CLERGY AND IMAMS</li> <li>• CLAN CHIEFS</li> <li>• PARLIAMENTARIANS</li> <li>• COUNCILORS</li> <li>• TEACHERS</li> <li>• POLITICAL AND SOCIAL ACTIVISTS</li> </ul>	<ul style="list-style-type: none"> <li>• Endorse publicly, PWD FP/RMNCH messages and activities</li> <li>• 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/RMNCH</li> <li>• 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/RMNCH</li> </ul>

### 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
AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
POLICY MAKERS, MINISTERS FOR HEALTH, EDUCATION, YOUTH, HUMAN RIGHTS, MEMBERS OF PARLIAMENT	<ul style="list-style-type: none"> <li>• Endorse a gender sensitive lens for supporting adoption of health promoting FP/RMNCH behaviors.</li> <li>• Endorse PWD messages and activities.</li> </ul>
SENIOR BUREAUCRATS AT PROVINCIAL LEVEL	
DISTRICT OFFICIALS	

## Policy & Institutional Communication & Engagement Objectives

- I. **Create Descriptive Norm:** Office bearers 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:** Office bearers believe that they are expected to practice the target behaviors, and these are socially approved.
  - b. **Improve Outcome Expectation:** Office bearers believe that the outcomes of practicing target behaviors have substantive benefits for individuals, community, and nation at large. Office bearers 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 (CPOs), and government office bearers 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/RMNCH services across Sindh. Interventional approaches for supporting Strategy 2 are informed by the **PWD Sindh Media and Male Engagement Strategies for Family Planning 2024**.

### 1. MOVEMENT BUILDING TO RALLY SOCIETAL INFLUENCERS AS ADVOCATES FOR FAMILY PLANNING.



#### Key Activities

- 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 CPOs with the necessary tools to address socio-cultural norms surrounding FP/RMNCH 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.

**v. 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/RMNCH. Different policy-level advocacy events will be undertaken to mobilize policy commitments to family planning in Sindh. 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:



### Key Activities

**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/RMNCH, 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:** PWD will strengthen existing partnerships and establish new strategic media partnerships, and all activities and events involving societal influencers such as CPOLs and Office bearers be designed to receive high visibility media coverage to maximize their impact and reach. Through strategic media partnerships, these initiatives will be promoted extensively across various platforms, garnering public attention and engagement. Support and assistance available from development partners will be leveraged as needed.

**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/RMNCH 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 Office bearers to foster inter-generational exchange of ideas and perspectives, contributing to the promotion of family planning and gender equality.

## Foundational Resources & IEC Materials 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.

Table 3 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.

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/RMNCH 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. 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 3: Materials and Content needed for different channels for supporting Strategy 2**

S. No.	CHANNELS	MATERIALS
1	All channels	<ul style="list-style-type: none"> <li>PWD SBC Strategy campaign branding and marking guidelines</li> <li>Key messages for audience segments on relevant behaviors</li> </ul>
2	CPOs and Societal Influencers	<ul style="list-style-type: none"> <li>Resource Book/Guidance for Norm Shifting Advocates</li> </ul>
3	Community signposting	<ul style="list-style-type: none"> <li>Banners, Billboards, and Community signposting through branded vehicles and branded signposting for facilities</li> </ul>
4	Local Cable Television	<ul style="list-style-type: none"> <li>Scripted Audio/Video PSAs</li> <li>Broadcast plan for Talk Shows</li> </ul>
5	Social media	<ul style="list-style-type: none"> <li>Social media strategy and content</li> <li>Activity SOP and plan for Virtual WhatsApp networks</li> <li>IEC content including AV</li> </ul>
6	Community Events	<ul style="list-style-type: none"> <li>Branded content and creative design for all community event branding</li> </ul>

## 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/RMNCH. 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 mores 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.

## **CPOs, 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 CPOs, household elders and influencers such as mothers-in-law.
- CPOs, and household influencers like the mother-in-law may experience awkwardness, embarrassment, and even shame when being encouraged to discuss issues related to FP/RMNCH, 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.

# Strategy 3



## 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 Sindh, 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/RMNCH 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/RMNCH 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

<b>PRIMARY AUDIENCE</b>	<b>COMMUNITY MEMBERS AFFILIATED WITH CBOS</b>
<b>AUDIENCE SEGMENTS</b>	<b>KEY BEHAVIORS TO PROMOTE</b>
COMMUNITY BASED ORGANIZATIONS (CBO) LEADERS	<ul style="list-style-type: none"> <li>Endorse a gender sensitive lens for supporting FP/RMNCH services for men and women in their communities</li> <li>Endorse and support PWD FP/RMNCH messages and activities</li> </ul>
COMMUNITY BASED ORGANIZATIONS (CBO) FUNCTIONARIES AND REPRESENTATIVES	<ul style="list-style-type: none"> <li>Lead, support, and facilitate community led SBC and engagement activities for supporting activities described under the PWD SBC Strategy for Sindh.</li> </ul>

## 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/RMNCH 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 skilled of skilled FP/RMNCH 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/RMNCH 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/RMNCH 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/RMNCH 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/RMNCH service by men and women

## Interventional Approach and Activities

Community engagement approaches for supporting Strategy 3 are informed by the PWD Sindh Male Engagement Strategy for Family Planning 2024 and 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 <sup>1</sup>.

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<sup>1</sup> 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.

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. BUILD CRITICAL CONSCIOUSNESS AND FACILITATE ISSUE SELECTION

### Focus

- ▼ 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/RMNCH including harmful gender norms resulting in negative FP/RMNCH outcomes.



### Key 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

### Focus

- ▼ 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.



### Key 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/RMNCH 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/RMNCH, 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.

### 3. SUPPORT COMMUNITY CAPACITY FOR SOCIAL ACTION AND FACILITATE EMPOWERMENT

#### Focus

- ▼ 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/RMNCH efforts with multisectoral and economic empowerment approaches.



#### Key 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/RMNCH agenda stemming from this strategy. Materials and communication collaterals developed for Strategies 1 and 2 will directly feed into a range of possible activities, with CBOs potentially leading and supporting some or all the activities. These CBO-led activities would operate at a community level and will be incrementally rolled out with technical assistance, oversight, and stewardship from PWD and partners, and may include the following:

**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/RMNCH

- 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/RMNCH. These will be specifically designed to support interventions promoting PFP 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, including those from marginalized and vulnerable groups, 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/RMNCH behaviors

### Audience and Target Behaviors

PRIMARY AUDIENCE	HEALTHCARE PROVIDERS (HCPs)
AUDIENCE SEGMENTS	KEY BEHAVIORS TO PROMOTE
<b>FACILITY-BASED HEALTHCARE PROVIDERS:</b> DOCTOR, NURSE, LADY HEALTH VISITORS (LHVs), COMMUNITY MIDWIVES (CMWS)	<ul style="list-style-type: none"> <li>• Provide high quality, person-centered, counselling and services for PFP to women and couples during antenatal, natal, and post-natal care.</li> <li>• Provide high quality, person-centered, counselling for PAFP when delivering Post-abortion Care (PAC).</li> <li>• Deliver high quality, gender and youth sensitive respectful, person-centered FP/RMNCH counseling, products, and services.</li> </ul>
<b>COMMUNITY-BASED HEALTHCARE PROVIDERS:</b> LADY HEALTH WORKER (LHW), FAMILY WELFARE ASSISTANTS (FWA), COMMUNITY HEALTH WORKERS (CHWS)	<ul style="list-style-type: none"> <li>• Provide high quality, person-centered, counselling and services for PFP to women and couples during antenatal, and post-natal visits.</li> <li>• Provide high quality, person-centered, counselling and services for PAFP for women seeking and receiving Post-abortion Care (PAC).</li> <li>• Deliver high quality, gender and youth sensitive respectful, person-centered FP/RMNCH counseling, products, and services.</li> </ul>
<b>ALLIED HEALTHCARE PROVIDERS:</b> PHARMACISTS, RETAILERS	<ul style="list-style-type: none"> <li>• Provide high quality, person-centered, counselling and family planning products, inclusive of PFP and PAFP.</li> </ul>
<b>ALTERNATIVE HEALTHCARE PROVIDES</b> HAKEEMS, HOMEOPATHS	<ul style="list-style-type: none"> <li>• Provide correct information, counselling and referrals for family planning products and services, inclusive of PFP and PAFP.</li> </ul>

### 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/RMNCH 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/RMNCH 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/RMNCH 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/RMNCH 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/RMNCH.

## 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 by a range of structural and systems factors and this comprehensive approach is aimed at providing PWD, DoH, PPHI, and development partners in the SBC Sub-group and other stakeholders with a roadmap offering a range of potential interventions operating at various levels, providing program teams with flexibility to tailor their approach according to specific needs and contexts.



### Key Activities

- i. **Policy Level Interventions:** 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 and/or standards for PFP and PAFP in licensing requirements, and updating pre-service training curricula and materials to integrate principles of high quality, gender and youth sensitive respectful, person-centered FP/RMNCH counseling, products, and services.

**ii. Institutional Interventions:** 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/RMNCH counseling, products, and services, including graduating providers to role models.

**iii. Provider-Focused Intervention:** 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 PFPF 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 Gates Foundation. 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.

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. 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 PFPF and PAFP, and vice versa, among providers.
- iii. Establish prevalence of respectful, person-centered PFPF 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 PFPF 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 PFP 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 PFP 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.

**ii. Community Level Approaches:** PWD will collaborate with development partners to create linkages across strategies through community level approaches (Strategy 3.1) for PBC. These activities consist of engaging CPOL's, Office bearers, 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/RMNCH.

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 PFP 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/RMNCH services.

#### Household Audience 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	<ul style="list-style-type: none"> <li>Participate in consultative prioritization, planning, and implementation of SBC strategies, interventions, and activities.</li> <li>Prioritize SBC interventions in workplans and budgets for supporting availability and uptake of high quality, person-centered, gender sensitive FP/RMNCH services.</li> </ul>
DECISION MAKERS AND OFFICE BEARERS FROM DEVELOPMENT PARTNERS WORKING IN SBC FOR FP/RMNCH	<ul style="list-style-type: none"> <li>Participate in consultative prioritization, planning, and implementation of SBC strategies, interventions, and activities.</li> <li>Prioritize SBC interventions in donor-funded project workplans and budgets for supporting availability and uptake of high quality, person-centered, gender sensitive FP/RMNCH services.</li> </ul>
DISTRICT OFFICE BEARERS UNDER PWD, DOH, AND ASSOCIATED LINE DEPARTMENTS	<ul style="list-style-type: none"> <li>Develop and integrate SBC activities in district action plans.</li> <li>Prioritize SBC interventions in workplans and budgets for supporting availability and uptake of high quality, person-centered, gender sensitive FP/RMNCH services.</li> </ul>

#### 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 availability and uptake of high quality, person-centered, gender sensitive FP/RMNCH 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/RMNCH 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/RMNCH 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/RMNCH services in workplans and budgets.
- Believe that their values require them to participate in the consultative process and prioritize SBC interventions for FP/RMNCH services FP/RMNCH 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/RMNCH counseling and services, for women and men. Intervention Approaches are conceptualized at Provincial and District levels.

### 1. PROVINCIAL LEVEL STEWARDSHIP OF SBC STRATEGY

Activities at the provincial level are informed by the Informed by CCAT, operationalizing the stewardship theory of change presented in Section 2. This process is designed to enable PWD Sindh to engage with local actors and stakeholders in a cyclical and iterative five-phase process for SBC capacity strengthening and adaptive planning and 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/RMNCH:** 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 FP2030 SBC Sub-group, with clearly specified terms of reference, structure and confirming stakeholder involvement through a consultative process guided by the Technical Advisor and Focal Person FP2030.

**Phase 2: Establish funding and financing mechanisms for SBC FP/RMNCH:** Phase 2 of the implementation cycle focuses on ensuring uninterrupted financing to sustain multi-level SBC approaches across Sindh. 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 SBC Sub-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 Sub-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 Sindh.

### **Phase 3: Co-create activity designs, FP/RMNCH 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 PWD will use the comprehensive activities described in this strategy document to convene co-creation and prioritization session of the SBC Sub-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 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 Sub-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 Sub-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 Sindh. 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 related to family planning and other associated behaviors among youth, women and men in Sindh.

## 2. DISTRICT LEVEL STEWARDSHIP OF SBC STRATEGY

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.

### a. 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/RMNCH 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.



#### Key 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/RMNCH services, barriers to access, and key messages to promote effective stewardship of priority health areas through affirmative policy and implementation decisions supporting FP/RMNCH 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/RMNCH 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. Links to and crosses over with individual and interpersonal

level strategy. Links to and crosses over with individual and interpersonal strategies.

**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.

### 3. 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/RMNCH care, and link to social accountability approaches.
- ▼ Improve salience, knowledge and awareness regarding policy and regulatory quality mandates for FP/RMNCH 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.



#### Key Activities

**i. Community-led dialogue** with social advocates and decision-makers on FP/RMNCH, 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 monitoring 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.
- ▼ Institutional power dynamics and gender-based occupational segregation may impact access to priority FP/RMNCH 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.

# Implementation, Monitoring, and Evaluation



## Section 4: Implementation, Monitoring, and Evaluation

### Implementation Approach

The Sindh SBC Strategy for Family Planning and Reproductive Health (FP/RH) will initially be implemented in **three pilot districts**, carefully selected to represent diverse population contexts. These include: (i) **district Tando Allahyar**, which is also the provincial pilot for EPHS implementation; (ii) **one urban district within Karachi**, representing complex metropolitan dynamics; and (iii) **one rural district**, to test the implementation approach in low-resource settings. This geographic spread enables meaningful insights into district-level adaptation, integration, and scalability.

This strategy has been designed in alignment with the Sindh government's key priorities, including the prevention of gender-based violence, early childhood marriage, and the reduction of maternal and infant mortality.

The Implementation Framework is organized across **four interlinked implementation domains**. These domains were designed to facilitate **rapid partner alignment, strengthen operational clarity, and mobilize institutional and technical expertise** across government, private sector, and development partners. Together, these domains provide a structured basis for operationalizing the SBC Strategy in priority geographies and platforms.

### Key Implementation Domains

#### 1. Structural Changes for Improved Integration for Strengthening the Rollout of Services

This domain focuses on the institutional integration of FP/RH services between PWD & DoH Sindh and the establishment of joint stewardship structures for strengthening the rollout of services. It lays the foundation for coordination between PWD and DoH and aligns with Sindh's broader EPHS rollout.

#### Interventional Approaches:

- ▼ **Integration of FP/RH Services at district level facilities** – Includes district selection, pilot planning, stakeholder consultations, joint review by DoH and PWD, and tracking of implementation milestones for better coordination and strengthening of services through better coordination.
- ▼ **Joint Planning and Governance for improved stewardship of SBC** – Establishing and upgrading governance mechanisms such as FP2030 Subgroup, District Technical Working Groups and social media Cell, the development of costed implementation plans, fiscal space analysis, and stakeholder consultations.

## 2. Enabling Environment for Family Planning

This domain strengthens the systems that make FP information and services available and accessible. It spans both community and facility-level platforms, ensuring service quality, digital innovation, and logistical readiness. *The strategy will prioritize focusing on cost-effective activities within existing resources such as the community led activities by LHWs (village committees, women support groups etc.).*

### Interventional Approaches:

- ▼ **Increased availability of Community-based services** – Strengthening LHWs, FWAs, and male mobilizers through updated strategies, job aids, and supervision systems.
- ▼ **Increased availability of Facility-based services** – Focuses on improving couple counseling, male counseling corners, male FP service delivery, NSV training for surgeons, and strategic alliances with programs like BISP.
- ▼ **Strengthened supply chains and logistics** – Identifies and addresses supply chain bottlenecks for FP commodities and equipment through rapid assessments and action plans.
- ▼ **Digitization of public and private sector service providers** – Integrate digital health marketplaces (apps) with public and private sector healthcare providers / social marketing organizations.

## 3. Improved Implementation of Legislative and Regulatory Provisions

This domain enables rights-based SBC by embedding awareness and application of legal frameworks within community and provider networks. It leverages both social accountability and institutional engagement.

### Interventional Approaches:

- ▼ **Community Engagement & Participation for Legislative Implementation** – Establishes district engagement platforms and disseminates IEC.
- ▼ **Engagement of Service Providers for supporting Provider Behavior Change (PBC)** – Develops charter of rights and responsibilities, trains providers on legal mandates, produces provider-facing IEC, and facilitates peer learning through virtual groups.
- ▼ **Policy and Institutional Orientations and Dialogue** – Includes the development of policy-focused IEC materials, district orientations for implementers, and seminars to promote awareness and enforcement of RH-related laws.

## 4. Communication for Increasing Demand and Utilization

This domain operationalizes SBC through multi-channel communication strategies targeting different audiences. It combines harmonized messaging with strategic use of interpersonal,

mid-media, and mass media tools. The strategy puts special focus on leveraging social media in Sindh for disseminating health messaging.

### **Interventional Approaches:**

- ▼ **Message and Content Harmonization** – Focuses on audience-specific message development, validation processes, and the rollout of the Sindh SBC for FP Communication Toolkit.
- ▼ **Interpersonal Communication (IPC)** – Strengthens IPC delivery by both community- and facility-based providers, including tailored IEC materials, supportive supervision, provider recognition, and digital platforms for outreach.
- ▼ **Mid-media** – Includes community meetings, intergenerational dialogues, targeted group counseling, community events, and visibility through signposting in public spaces.
- ▼ **Mass Media** – Encompasses TV, radio, print, and digital/social media engagement, including media engagement through partnerships, multi-channel mass media campaigns aimed at a range of audiences, and leveraging societal and social media influencers.

### **Phased Implementation Cascade**

1. **Development of costed action plans** with clearly defined partner roles and contributions
2. **Collaboration and Review** by relevant government authorities at the district and provincial level
3. **Production of IEC materials and operational resources**
4. **Implementation of interventions and routine tracking of progress** through MEL systems

Together, this Implementation Framework and its associated activities and timeline offer a **clear and actionable roadmap for engagement, prioritization, and coordinated delivery**. It is designed to facilitate **joint action planning with provincial and district stakeholders, technical agencies, and development partners**.

The emphasis on inclusive governance and stewardship is embedded under **Implementation Area 1.2**, which guides the establishment of sustainable institutional mechanisms for SBC coordination in Sindh by strengthening the FP2030 SBC Working Group.

# 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 the 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/RMNCH 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 4: Key Indicators and Sources of Data for Monitoring**

S/No	WHAT	WHERE	HOW	WHEN	WHO
	<i>Indicator</i>	<i>Source of Data</i>	<i>Data Collection Tool</i>	<i>Frequency of Data Collection</i>	<i>Focal Partner</i>
<b>Individual Level</b>					
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	WHERE	HOW	WHEN	WHO
	<i>Indicator</i>	<i>Source of Data</i>	<i>Data Collection Tool</i>	<i>Frequency of Data Collection</i>	<i>Focal Partner</i>
<b>Individual Level</b>					
1.8	# Referrals by community-based workers	Activity report	CHW register, referral slips, health facility registration	Monthly	TBD
<b>Household level</b>					
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
<b>Community level</b>					
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
<b>Facility / Provider Level</b>					
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
<b>Institutional &amp; Policy Level</b>					
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/RMNCH 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/RMNCH service availability and uptake?
4. What is the level of engagement for community influencers in implementing community engagement activities that promote adoption of target FP/RMNCH behaviors?
5. How did the interventions improve provider behaviors related to provision of high quality, gender, and youth responsive, person-centered, respectful FP/RMNCH 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/RMNCH services?

**Table 5: Key Indicators and Sources of data for SBC Strategy Evaluation**

S/No	WHAT	WHERE	HOW	WHEN	WHO
	Indicator	Source of Data	Data Collection Tool	Frequency of Data Collection	Focal Partner
<b>Individual Level</b>					
<b>Immediate (Psychosocial outcomes)</b>					
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
<b>Intermediate (Behavioral outcomes)</b>					
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
<b>Household Level</b>					
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 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
<b>Institutional &amp; Policy Level</b>					
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

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# Annexures



# ANNEX 1: DIAGNOSIS AND NEEDS ASSESSMENT

## National Context

Pakistan is the fifth most populous country in the world with a population of 241.49 million. 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. Pakistan is poised for continued population expansion, projected to reach approximately 403 million by the end of the century.

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.

## Socio-Demographic Landscape in Sindh

Sindh, Pakistan's second-largest province by population, is home to 56.3 million people. With an average annual growth rate of 2.41 percent, this is estimated to grow to 95.7 million souls by 2050. The gender distribution is nearly equal, and the average age of the population is 25 years, reflecting a predominantly youthful demographic profile.

Sindh's per capita GDP, primarily driven by Karachi, stands at \$2,413, surpassing the national average. Over half of the province's population resides in urban areas. Karachi, the capital of Sindh, serves as the commercial, technological, and media hub of Pakistan, boasting a thriving culture for performing arts and housing the national headquarters for leading e-commerce, media, and production houses.

Apart from Karachi and other urban centers, Sindh heavily depends on agriculture. Socially, Sindh celebrates diversity in religion and ethnicity, boasting significant representation from Islam, Hinduism, Sikhism, and Christianity. Various ethnic groups such as Sindhis, Pushtoons, Urdu-Speakers, Punjabis, and Saraikis contribute to the province's diverse demographic fabric. Sindh's rich cultural heritage, influenced by its Sufi history, fosters an environment of openness and acceptance of novel ideas, positioning it favorably to advocate for the government's family planning. Renowned Sufi poets like Shah Abdul Latif Bhitai and Lal Shahbaz Qalandar have championed tolerance for all faiths and ethnicities, enhancing the province's vibrant demographic landscape, which also experiences considerable inward migration from neighboring regions.

Wide disparities exist in **socio-economic status**, with greater levels of poverty in rural areas compared to urban areas of the province. In Sindh, the lowest quintile comprises 36.3% of the population, while the highest quintile constitutes 17.9%. Urban regions show a concentration of wealth, with the lowest quintile at 5.5% and the highest at 34.0%. Conversely, rural areas exhibit higher proportions in the lowest quintile (68.7%) and lower in the highest (1.0%). These findings highlight disparities, necessitating targeted interventions for equitable economic development.

**Table 6: Socioeconomic Profile of Sindh - % distribution across wealth quintiles by residence**

	Lowest (%)	Second (%)	Middle (%)	Fourth (%)	Highest (%)
<b>Sindh</b>	36.3	13.6	13.1	19.1	17.9
Urban	5.5	8.5	18.1	33.8	34.0
Rural	68.7	18.9	7.8	3.6	1.0

**Educational attainment** in Sindh varies across different stages and demographic groups, as indicated by the percentages of the population reaching various levels of education. A notable portion of the population has achieved primary and secondary education, with fewer individuals reaching higher education. Specifically, 54.7% of women and 28.2% of men have no education, while 13.1% of women and 19.5% of men have completed primary education. Middle education is attained by 7.8% of women and 9.2% of men, secondary education by 11.1% of women and 16.1% of men, and higher education by 13.3% of women and 27.0% of men.

**Table 7: Educational Attainment in Sindh - % 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
<b>Sindh</b>	54.7	28.2	13.1	19.5	7.8	9.2	11.1	16.1	13.3	27.0
Urban	31.4	13.8	14.4	15.5	12.2	11.9	18.8	22.0	23.2	36.8
Rural	81.5	46.7	11.6	24.7	2.7	5.7	2.4	8.4	1.8	14.4

Examining **educational attainment by residence** reveals stark disparities between urban and rural areas. In urban regions, 31.4% of women have received no education, compared to rural areas, where 81.5% of women have not received any education. In urban areas, a lower percentage of individuals have no education compared to rural areas. Specifically, 31.4% of urban women and 13.8% of urban men have no education, whereas in rural areas, these figures rise to 81.5% for women and 46.7% for men. Urban residents have higher percentages of individuals completing higher education, with 23.2% of urban women and 36.8% of urban men achieving this level, compared to 1.8% of rural women and 14.4% of rural men. 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 Sindh, women are more likely to have no education compared to men, with 54.7% of women and 28.2% of men falling into this category. Men generally attain higher education levels more frequently than women. For instance, 27.0% of men have completed higher education compared to 13.3% of women. While primary and middle education levels show less disparity, men still lead with 19.5% having completed primary education compared to 13.1% of women, and 9.2% completing middle education compared to 7.8% of women. 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 Sindh.

## Maternal and Child Health Outcomes

A clear need for health system intervention is indicated by a comparison of key health outcome indicators between Sindh and the national averages for Pakistan.

**Table 8: Maternal and Child Health Outcomes in Sindh, compared to national average**

	Sindh	National Average
Maternal Mortality Ratio	224	154
Neonatal Mortality Rate	24	42
Infant mortality rate /1000 live births	39	53
Under 5 Mortality Rate / 1000 live births	46	67

Sindh demonstrates a maternal mortality ratio (MMR) at 224 per 100,000 live births and neonatal mortality rate (NMR) at 24 per 1000 live births which is comparable to the national average of MMR at 224 per 100,000 live births, and NMR at 24 per 1000 live births.

However, Sindh exhibits a notably higher infant mortality rate (IMR) and under 5 mortality rate at 39 and 46 deaths per 1000 live births, respectively, compared to the national averages of IMR at 53 and under 5 mortality rate at 67 deaths per 1000 live births. Addressing these gaps requires targeted interventions to empower women and improve reproductive and child health services, especially in rural areas.

## Fertility

The overall total fertility rate (TFR) for Sindh stands at 3.7 children per woman, with urban areas exhibiting a lower TFR of 2.9 compared to rural regions with a TFR of 4.6.

**Table 9: Total Fertility Rate and Adolescent Birth Rate in Sindh, by residence**

	Total Fertility Rate	Adolescent Birth Rate (per 1000 females)
<b>Punjab</b>	3.7	49
Urban	2.9	36
Rural	4.6	66

This disparity between urban and rural TFRs suggests varying reproductive behaviors and potentially distinct socio-economic factors influencing family planning practices within these settings. Additionally, the adolescent birth rate (ABR) presents notable differences, with an overall ABR of 49 births per 1000 females aged 15-19 years in Sindh. Urban areas report a lower ABR of 36, contrasting with rural areas recording a higher ABR of 66, suggesting a high unmet need among adolescents and youth. 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.

The PDHS 2017-18 indicates that 61% MWRA either want no more children, want a child after two years, or are unsure about when they want to have their next child. 21% MWRA with two children and 52% MWRA with three children want no more children. The desire to limit fertility matures with the birth of the third child and becomes strong after the fourth child with more than 70% MWRA with four or more children wanting no more children. This desire to regulate fertility represents strong latent demand for family planning, however, the mCPR in Sindh has remained relatively stagnant since 2007 with over 10% of MWRA in Sindh reporting a history of induced abortion for fertility management, consistently since 2012-13.

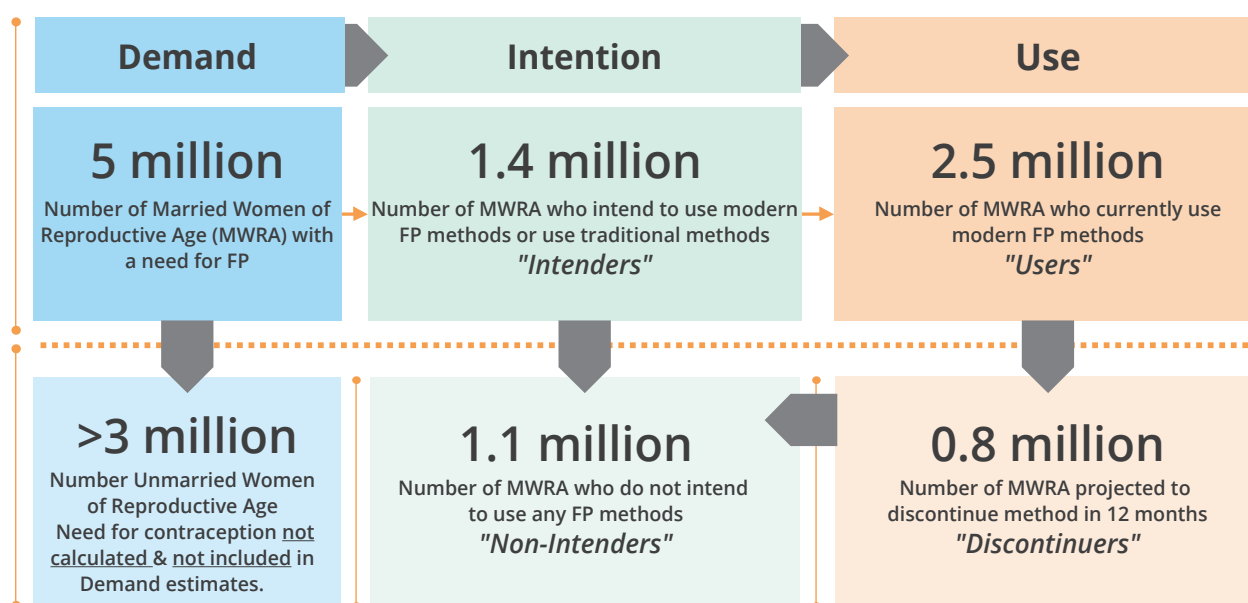
## Demand, Use and Unmet Need for Family Planning

Just over 60% of MWRA in Sindh either want no more children, want a child after two years, or are unsure about when they want to have their next their child indicating a strong latent demand for family planning. Of the 10 million plus MWRA in Sindh, 48% have a need for FP. Of these 29% of MWRA report a need for limiting, while 19% MWRA report a need for spacing. 52% report having no need for FP (are pregnant, intend to get pregnant, or do not want to limit or space births).

The demand for FP in Sindh is significantly under-served, with an estimated 5 million Married Women of Reproductive Age (MWRA) needing FP services (Figure 6). Currently, around 50% of this demand is met through modern FP methods, leaving over 2.5 million MWRA with an unmet need. Within this group, 1.4 million women intend to use modern or traditional FP methods, while 2.5 million are active users of modern methods.

Among currently using MWRA the method mix is dominated by female sterilization (42 percent), indicating a strong reliance on permanent methods among older women. This is followed by male condoms (22 percent), with other methods including injections (9 percent),

Figure 6: Distribution of Family Planning Users in Sindh



pills (6 percent), implants (5 percent), and IUDs (4 percent) making up smaller shares. This distribution highlights both the heavy skew toward sterilization and the opportunity to expand the uptake of short-term and spacing methods to better meet diverse reproductive intentions and life stages. However, a notable gap exists, with 1.1 million MWRA expressing no intention to use any family planning methods and 0.8 million expected to discontinue their use within the next 12 months.

The estimated need also fails to account for more than three million unmarried women of reproductive age who may require contraception but are not included in the current demand estimates. This exclusion indicates a substantial underestimation of the total need for family planning in the region.

## Demand, Use, and Unmet Need for Limiting Births

Of the 1.9 million married women of reproductive age (MWRA) in Sindh who have a need for limiting births, 64 percent are already using a modern family planning method, while 36 percent are not, indicating a moderate level of unmet need for limiting births.

Among those using contraception, the vast majority rely on female sterilization (54 percent), followed by male condoms (22 percent), injections (9 percent), pills (6 percent), implants (5 percent), and IUDs (4 percent). Usage is concentrated among older women with an average age above 35 years.

Importantly, of the non-users, 33 percent intend to adopt a method in the future, pointing to a critical opportunity to convert intention into sustained use. Additionally, both users (37 percent) and non-users (34 percent) report notable histories of induced abortion, highlighting the importance of expanding access to effective limiting methods to reduce unintended pregnancies and improve reproductive health outcomes.

## Demand, Use, and Unmet Need for Spacing Births

Among the 2 million married women of reproductive age (MWRA) in Sindh who have a need for birth spacing, only 30 percent are currently using a modern family planning method, leaving a substantial 70 percent not using any method. This highlights a significant unmet need for spacing that presents an opportunity to reduce unintended pregnancies and improve reproductive health outcomes through targeted interventions.

The method mix among those using contraception for spacing is primarily dominated by male condoms (56 percent), followed by pills (19 percent), injections (17 percent), implants (6 percent), and a small share using IUDs (1 percent). This indicates a preference for short term and user-controlled methods among younger women with an average age of 28 years, suggesting delays in contraceptive debut, and highlighting a great level of unmet need among young women.

Notably, 55 percent of non-users express an intention to adopt a method in the future, reflecting considerable latent demand that can be leveraged through focused social and behavior change strategies and improved service delivery. Additionally, both users (26 percent) and non-users (28 percent) report notable histories of induced abortion, highlighting the importance of expanding access to effective limiting methods to reduce unintended pregnancies and improve reproductive health outcomes.

## Understanding MWRA's Use and Intention for Family Planning

Data from the PDHS 2017-18 reveal important disparities in modern family planning use, method choice, intention to use, and non-intention among MWRA in Sindh, helping to conceptualize profiles of priority target audience segments for this strategy.

These differences, shaped by MWRA's age, whether they live in urban or rural areas, and their household's economic status point to critical opportunities for targeted action and have directly informed the priorities and approaches laid out in this strategy.

## MWRA Currently Using modern Family Planning methods

In Sindh, current use of modern family planning methods varies by the life circumstances of MWRA including their age, where they live, and their household's economic position. Among the 2.5 million users, very few younger MWRA aged 15-19 years are using contraception, with fewer than 50,000 users overall. Among them, most rely on condoms (67 percent), followed by injectables (17 percent) and pills (8 percent). MWRA aged 20-29 years show slightly more diversity in method choice but still predominantly use condoms (42 percent) and female sterilization (17 percent). For MWRA aged 30-49 years, who make up the largest group of users, the picture shifts heavily to female sterilization (52 percent), with some continuing use of condoms (24 percent) and smaller shares using pills, injectables, and implants.<sup>5</sup>

MWRA living in urban areas also largely depend on condoms and sterilization, showing that even in settings with typically better access, the method mix remains narrow. Similarly, MWRA

from wealthier households continue to concentrate on these same few methods, suggesting that greater financial means alone does not necessarily lead to wider contraceptive choice.

An important dimension of the user profile in Sindh is the high rate of contraceptive discontinuation, with nearly 30 percent discontinuing within one year, largely due to inadequate counseling, adverse experiences with long-acting methods, and poor technical quality of care. The data show that male condoms (39 percent), injectables (31 percent), and pills (20 percent) are the most commonly discontinued methods. Reasons vary by method, but side effects stand out as a dominant cause, reported by 57 percent of IUD users, 65 percent of implant users, and significant shares of injectable and pill users.<sup>5</sup>

These disparities point to differing reproductive intentions and life stages but also suggest significant gaps in access to and demand for appropriate spacing methods among younger women, and potentially an over-reliance on permanent methods among older cohorts. This highlights the need for age-responsive family planning strategies that expand informed choice, strengthen counseling on the full range of available methods, and address barriers unique to adolescents and young adults to support healthy timing and spacing of pregnancies. Findings also underscore critical need for improving the quality of counseling and follow-up support to ensure women are better prepared to manage side effects and can make informed, sustained choices aligned with their reproductive intentions.

## MWRAs with Intention to use modern Family Planning

Among the 2.5 million MWRA who are not currently using contraception, more than half (56 percent) express an intention to start. MWRA aged 20-29 years have the highest proportion intending to use a method (38 percent), while those aged 30-49 years make up the largest absolute number, with around 0.7 million intenders. MWRA living in urban areas not only show a higher proportion intending to adopt family planning (39 percent) but also account for 0.9 million women ready to translate intention into action. By household wealth, MWRA in the fourth wealth quintile have the highest proportion (40 percent) intending to use, but it is actually MWRA in the lowest wealth quintile who form the largest absolute group with unmet demand, around 0.5 million women.<sup>5</sup>

The data show that many younger MWRA aged 20-29 years and those from the lowest wealth quintiles, despite intending to use a method, likely face knowledge and skill gaps that limit confident adoption. MWRA living in urban areas and poorer households may still confront environmental constraints like inconsistent access, quality concerns, or cost barriers, while deeply rooted social norms and taboos continue to shape the experiences of younger and poorer women in particular, dampening the social salience needed to act. Together, these patterns highlight that while intention is strong, these groups require focused interventions to overcome informational, structural, and normative barriers and fully translate intention into use.

## MWRAs with No Intention to use modern Family Planning

Over 1 million MWRA in Sindh with a need for FP neither use contraception nor intend to do so.<sup>5</sup> This group is especially common among the youngest MWRA (15-19 years) who may not

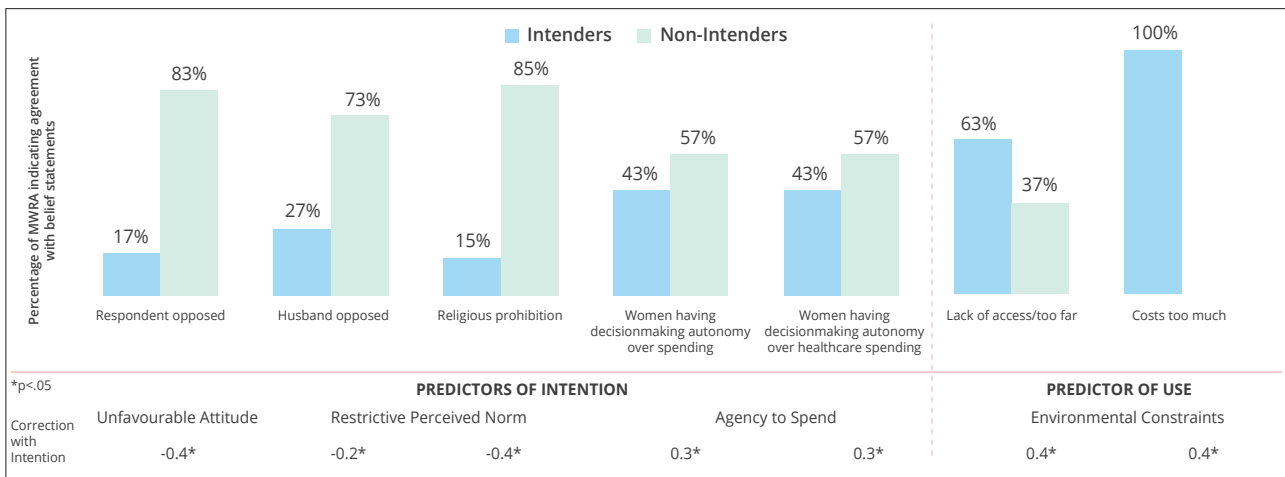
This group is especially common among the youngest MWRA (15-19 years) who may not yet feel the need, and among some older MWRA aged 30-49 years who may consider their families complete. Non-intenders are more frequently found in rural areas and among poorer households, and underscore the presence of perceptual barriers, unfavorable social norms, limited autonomy, and fewer opportunities to engage with FP messages or services.

These challenges are especially evident among the youngest MWRA aged 15-19 years, those living in rural areas and among MWRA belonging to poorer households, where restrictive expectations and lower exposure to supportive messaging are more common. These findings highlight key audience segments that require targeted approaches to address these barriers.

### Predictors of Family Planning Use and Intention in Sindh – A Theory-Driven Assessment

The PDHS 2017-18 provides insight into predictors key predictors influencing the intention and use of family planning among MWRA in Sindh. A theory-driven correlational analysis (Figure 7) reveals a high prevalence of unfavorable predictors of intention, such as personal opposition, potential fear of side effects, opposition from husbands, religious prohibitions, and limited agency to spend, predominantly among non-intenders compared to intenders. Additionally, the data emphasizes that lack of access or distance to FP services and the cost of these services are the primary barriers to FP adoption among those who intend to use it.

Figure 7: Predictors of Family Planning Intention & Use among MWRA in Sindh



**Predictors of Intention to use family planning:** There is a significant difference between intenders and non-intenders concerning opposition factors. For instance, 83% of non-intenders reported personal opposition compared to only 17% of intenders, and 73% of non-intenders face opposition from husbands versus 27% of intenders. Religious prohibition is a barrier for 85% of non-intenders, whereas only 15% of intenders cite it as a factor. Autonomy in decision-making over spending impacts intention, with 57% of non-intenders lacking autonomy compared to 43% of intenders. Similarly, decision-making autonomy over healthcare spending is lower among non-intenders (57%) than intenders (43%). Correlations with intention show that unfavorable attitudes (-0.4), restrictive perceived norms (-0.2), and agency to spend (0.3) significantly influence the likelihood of intending to use family planning.

**Predictors of family planning use:** Environmental constraints such as lack of access or distance to FP services affect 63% of non-intenders, while only 37% of intenders report this as a barrier. Additionally, cost barriers are perceived by all non-intenders (100%) compared to only 37% of intenders. The predictors of use indicate that both lack of access/distance (0.4) and cost (0.4) have a moderate negative correlation with the adoption of FP services, suggesting that these environmental constraints are substantial factors preventing women from using FP services effectively.

## Family Planning Services in Sindh – Supply Perspective

An assessment of the family planning supply landscape in Sindh highlights critical insights into how MWRA interact with the healthcare system, their exposure to counseling on family planning during these interactions, and the quality of counseling when it does occur. These findings reveal important gaps in both reach and content, shaping the extent to which services translate into informed, confident uptake of contraception. Understanding these supply-side dimensions has been essential to ensure that the SBC strategy does not operate in isolation but is closely aligned with evidence-based service delivery initiatives, supporting more holistic and sustainable family planning outcomes across the province.

**Availability of FP/RMNCH Services:** The data on family planning barriers in Sindh highlights challenges in accessing essential maternal and postnatal care services. While 76.7% of women receive antenatal care by skilled personnel, there is relatively low coverage of Lady Health Workers (LHWs) at 42.7%, and access to frontline healthcare providers remains limited.<sup>5</sup> Additionally, accessing postnatal care for newborns and mothers stands at 56.4% and 56.5%, respectively, indicating gaps in critical support and counseling on family planning during the postpartum period.

**Post Partum Counseling on Family Planning:** The data show that during their most recent pregnancy ending in a live birth, less than 30 percent of MWRA in Sindh reported receiving any counseling on family planning before leaving the health facility. Specifically, only 28.9 percent were counseled on family planning, 27 percent were told about methods, and just 23.3 percent were guided on where to obtain family planning services. These proportions were almost identical across rural and urban areas, indicating limited geographic variation. Similarly, when comparing the public (26.4 percent counseled) and private sectors (31 percent counseled), differences were modest, revealing that both sectors fall short in systematically integrating family planning counseling within routine reproductive health encounters. This highlights a critical missed opportunity to strengthen postpartum family planning through more consistent, sector-wide counseling efforts.

**Quality of Counseling for Family Planning:** The PHDHS 2018-18 notes gaps in the quality of counseling provided to family planning users in Sindh. A striking 41 percent of current users were not informed about any of the three essential Method Information Index (MII) components, while only 21 percent received counseling that covered all three topics. Among individual indicators, 66 percent were told how to manage side effects, 50 percent were informed about other family planning methods, and just 37 percent were counseled about side effects themselves. This underscores that while certain aspects like managing side effects are more commonly addressed, comprehensive, client-centered counseling that fully equips

## Post Pregnancy Family Planning (PpFP) – A Missed Opportunity

- ▼ 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.
- ▼ According to the PDHS 2017-18, couples' desire for another child decreases with the birth of each child, however, the adoption of PPFP in Sindh, despite substantial investments and remarkable progress in provision of PPFP, adoption remains low. Of the annually estimated 1.4 million births in the province, an estimated 520,000 women adopt a modern contraceptive method in the post-partum period. This crude estimates suggests that annually there are almost 900,000 women in Sindh who need but do not use PPFP.
- ▼ This is not surprising given that less than one-third of women who deliver at a facility are counseled or even informed about family planning methods. Similarly, an alarmingly low proportion 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.
- ▼ According to last available estimates, of the 2.1 million annual pregnancies in Sindh, an estimated 44% are unintended pregnancies. Of these, 62 percent (572,000) are managed through induced abortions, while 12 percent (106,000) result in miscarriages. These crude estimates underscore that annually there may be as many as 700,000 women in the province with a need for PAFP. While reliable data on PAFP adoption and continuation rates in the province, are not readily available, current evidence suggests that uptake of long-term PAFP remains low.
- ▼ These data highlight substantial gaps in integration of PPFP and PAFP services in secondary, tertiary, and specialized centers, and PWD 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 across Sindh.

women with information to make informed choices remains limited, highlighting a critical area for strengthening provider communication and interpersonal counseling quality within the SBC strategy.

**Interaction with the Healthcare Sector:** The data show that more than half of MWRA in Sindh had some form of contact with the healthcare system in the past year. About 77 percent of intenders, 69 percent of users, and 60 percent of non-intenders reported visiting a health facility, while 61 percent of intenders, 56 percent of users, and 50 percent of non-intenders had been visited by a fieldworker. This high level of interaction across all groups, including non-intenders, highlights a valuable opportunity to leverage existing service touchpoints for more consistent and targeted family planning counseling.

**Sources of FP Information:** Despite frequent contact with health providers, discussions specifically about family planning lag behind, with only 24-29 percent of MWRA reporting that FP was discussed during their facility visits. Fieldworkers were a stronger source, with 47-56 percent indicating they received FP information this way. Mass media played a more limited role, reaching just 21-29 percent. These patterns suggest that health workers, especially at the community level, remain the most effective channel for personalized FP messaging, but also point to underutilized potential in health facilities and broader media platforms.

In Sindh, television is the primary media channel for both women (51%) and men (55%), yet family planning (FP) messages remain limited in reach, with only 23% of women and 44% of men reporting recent exposure. This disparity is especially evident among rural, less educated, and low-income groups. Additionally, 47% of women and 36% of men lack access to any form of media, highlighting the need for targeted approaches to reach underserved populations.

Men have greater access to newspapers (27% vs. 5%) and radio (8% vs. 4%). Interestingly, TV reach declined from 56% to 51% in the last five years. This emphasizes the need for FP campaigns tailored to low-education, low-income, and rural audiences, using simpler messaging and community-based mediums that address key barriers. According to a household survey conducted in 2022 by the now defunct USAID, only 36% of married women of reproductive age (MWRA) recall FP messages, primarily from healthcare providers, outreach workers, and television. For unmarried youth, 64% receive FP information from friends. Television remains the most effective mass media platform, with 4% of MWRA, 20% of married men, and 16% of unmarried young females and males citing it as a source for FP messages in Sindh.

**Types of Messages Received:** Among MWRA who received FP messages, the most common themes recalled were about birth spacing (45-52 percent), followed by maternal and child health (36-38 percent), and messages linking smaller families to prosperity (32-40 percent). This shows that while key messages on spacing and health are reaching significant segments of MWRA, there is scope to deepen engagement with messages that also address personal agency, social support, and broader life aspirations, particularly tailored to the needs of non-users and non-intenders.

These insights underline that while many MWRA in Sindh are already interacting with health systems and hearing some FP messages, critical gaps remain in the depth, consistency, and reach of family planning communication, especially for non-users and non-intenders. This presents a clear opportunity for the SBC strategy to strengthen counseling during routine facility and fieldworker interactions, expand use of mass media and digital platforms, and tailor content to address diverse motivations, aspirations, and social influences that can move MWRA from awareness to confident, informed action.

## 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,

products, and services, particularly concerning FP/RMNCH.

The diagnosis of family planning behaviors is informed by an empirical, theory-driven assessment of predictors of intention and use of family planning in Sindh, application of a gender lens to describe the construal of gender roles, the role of men in family planning and reproductive health behaviors, and men's readiness for fertility regulation. Following this the PRECEDE Framework was applied to summarize and describe the ecology of poor FP/RMNCH behaviors among women by describing Predisposing, Reinforcing, and Enabling factors driving these behaviors.

## Predisposing Factors

Predisposing factors encompass individual-level psychosocial elements that influence adolescents, 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. Salient predisposing factors impeding development of family planning intention, adoption of a modern method, and continued use are discussed below considering the observed impact on intention and use described using PDHS 2017-18 data.

**A High and Unchanging Desired Family Size, Driven by Son Preference:** In Pakistan, including Sindh, many couples have a relatively high ideal family size, averaging 3.7 children in urban areas and 4.9 in rural ones. Often, couples consider limiting pregnancies only after reaching four children, reflecting a trend where personal or cultural values support larger families. Since 2012, the mean ideal family size for men has remained consistent at 4.3, while for women,

## OVERVIEW OF KEY PREDISPOSING FACTORS

- ▼ Lack of individual Knowledge regarding FP/RMNCH 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/RMNCH associated behaviors.
- ▼ 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.

it stands at 3.9, showing a slight decline from previous surveys in 1990 and 2012. With a high urban population and youth demographic, the desired ideal number of children will determine advancements in family planning in the province in the times to come.

Son preference is a significant driver of large family sizes in many parts of Asia, including Pakistan. A recent 2020 study using three representative household surveys from Pakistan (PDHS 1990-91, 2006-07, and 2012-13) reveals strong evidence of differential reproductive behavior at early parities. Women whose first or second children are sons have significantly longer birth intervals compared to women without sons. The time couples wait before moving on to a subsequent pregnancy remains short as long as the desired number of sons is not born, leading to higher demands on the mother's body and greater health risks for both mother and child.

**Behavioral privacy and complexity of family planning:** Family planning remains a highly private and sensitive issue, tightly linked to cultural norms that restrict open discussion of sexual and reproductive health. Contraceptive use is treated as an individual or hidden household matter, limiting opportunities for women to observe or learn from others' experiences. This privacy, coupled with societal framing of sex primarily to fulfill husbands' needs and bear children, makes adopting family planning a complex, solitary decision that lacks broader communal support or positive emotional associations.

**Poor access to information and low digital literacy:** Access to family planning information in Sindh is uneven and limited, particularly among rural, less educated, and low-income groups. A large proportion of women and men lack exposure to any form of media, and even among those who do, family planning messages are not widely encountered. Television remains the primary source of mass communication, yet its reach has declined over time and still leaves significant gaps, especially for women. Many married women rely on healthcare providers and outreach workers for information, while unmarried youth mostly turn to friends. These patterns underline critical barriers posed by poor access to reliable information channels and low digital literacy, reinforcing the need for simple, community-focused communication approaches tailored to the realities of underserved populations.

**Limited access to family planning services:** Women face significant barriers in accessing family planning services, driven by a combination of supply-side gaps and deeply rooted social constraints. Many struggle with fear, anxiety, and mistrust of available care, compounded by stigma surrounding FP and reproductive health. Prevailing social and gender norms restrict acceptance of these behaviors, particularly for adolescents and youth, and reinforce low financial and decision-making autonomy. As a result, many women lack the confidence, permission, or means to travel, pay for services, or obtain contraceptive methods, leaving critical reproductive health needs unmet even during routine care visits.

**Unfavorable attitudes towards modern family planning:** Married women of reproductive age (MWRA) commonly evaluate modern family planning based on a simple tradeoff between perceived health risks and the utilitarian value of spacing births. While many recognize family planning as effective and wise for managing family size, widespread fears of harmful health effects persist. These broad, gist-based perceptions are shaped by limited accurate information and the prevalence of rumors, leading to overall cautious or negative attitudes toward adopting modern contraceptive methods.

**Low perceived agency to adopt family planning:** Perceived personal agency to use modern family planning varies significantly among MWRA. Women with more education, greater household wealth, delayed marriage, or more children generally feel a stronger sense of control and confidence in their ability to use contraceptives. Direct engagement with community health workers, referrals to service delivery points, and access to free services also bolster agency. In contrast, older women and those who had longer intervals since their last birth often feel less control, indicating that many MWRA face tangible and psychological barriers that diminish their ability to act on reproductive intentions. These stem from gender and social norms and are described under reinforcing factors.

**Poor perceptions of supportive social norms:** Norms around modern family planning are weak or unfavorable for many MWRA. Key influencers, including husbands and mothers-in-law, rarely initiate conversations or openly endorse contraceptive use, contributing to an environment where family planning is not actively encouraged. Younger and more educated women, as well as those with larger families, often perceive stronger expectations to bear more children and uphold traditional fertility norms, reinforcing restrictive views that discourage contraceptive use.

**Dissatisfaction and Negative Experiences:** According to the PDHS 2017-18, about 30% of couples discontinued contraceptive use within a year. Although 44% of those discontinuations were due to a desire for more children, reflecting the high ideal family size in the region, 35% of couples cited dissatisfaction with contraceptives. Health concerns and side effects accounted for 19%, while 16% stopped using them due to unintended pregnancies despite contraceptive use.

Pakistan's contraceptive method mix has been recognized as one of the least effective in reducing fertility since the 1990s. The focus on tubal ligation and condoms has contributed minimally to this goal. Although about half of all women seek services from the private sector due to easier access and active promotion, they are still limited to less effective methods. Addressing these concerns through better counseling, diversified contraceptive options, and improved user support could help increase satisfaction and demand.

## Reinforcing Factors

Reinforcing factors are pivotal in shaping individual predispositions towards FP/RMNCH 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.

**Early Marriage and Lack of Birth Planning:** In Pakistan, young women aged 15-19 are significantly more likely to be married than young men of the same age (14% vs. 3%). Early marriage exposes young women to increased risks of teenage pregnancy, affecting both their health and socioeconomic prospects while contributing to higher fertility rates.

Among women, 29% are married by age 18, and 47% by age 20, compared to just 5% and 14% of men, respectively. The median age of first marriage in Sindh reflects this gap, with women marrying on average at 20 years old (21.3 in urban areas and 18.4 in rural), while men marry at 26 years old (27.7 urban, 23.6 rural). These figures underscore the gender disparity in early marriage and its implications for young women's reproductive health and overall well-being.

**Traditional norms and misplaced trust in non-medical practices:** Household and community reliance on traditional remedies, home deliveries, and informal advice from faith healers or elders undermines trust in formal health services. These practices are often seen as safer or culturally appropriate, reinforcing low demand for skilled FP and reproductive health care. Such misplaced trust sustains harmful perceptions that modern services are unnecessary or even risky, diminishing intention among MWRA and men to seek or support contraceptive use.

**Gender roles, family pressures, and decision-making power:** Rigid gender norms and patriarchal structures give men, and often extended families, dominant authority over reproductive decisions. The PDHS data shows that 87% of married women using FP methods made the decision jointly with their husbands, while only 7% decided alone. Preference for sons, driven by expectations to secure lineage, avoid land disputes, and uphold family honor, further strengthens resistance to limiting births. These dynamics constrain women's autonomy, weaken spousal communication, and reduce both male and female motivation to adopt family planning.

**Limited male engagement and inadequate services for men:** While some men are beginning to see benefits of smaller families, such as reduced financial stress and more quality time with children, social expectations of masculinity tied to large families persist.

## OVERVIEW OF KEY REINFORCING FACTORS

### INSTITUTIONAL & POLICY LEVELS

- ▼ 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/RMNCH.
- ▼ Limited community capacity, comprehension, and ownership of priority health concerns.
- ▼ Minimal community involvement and inclusion in decision-making processes related to priority FP/RMNCH issues. And inadequate encouragement for timely utilization of skilled services FP/RMNCH.
- ▼ Lack of accurate knowledge and fatalism among household decision-makers and community influencers regarding the consequences of non-compliance with key behaviors.
- ▼ Widespread service provider bias towards contraception and provision of disrespectful FP/RMNCH care.
- ▼ Community adherence to harmful 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 regarding family planning use, particularly for younger women and young couples, and men's meaningful involvement beyond paying for care.

Many men also view themselves as the primary source of knowledge on FP, dismissing outside advice. Weak availability of male-focused FP services and poor management of contraceptive side effects discourage men from actively supporting spacing or limiting births, keeping their intention fragile and inconsistent.

**Collective households and lack of open dialogue:** Joint family systems are common, with decisions often shaped by multiple household members beyond the couple. The average household size in Pakistan is nearly seven, and only 12.5% are headed by women. In these settings, older family members impose expectations that discourage contraception, especially for younger couples. Cultural norms also severely limit candid discussions on reproductive health, leaving MWRA dependent on relatives who frequently lack accurate knowledge. This secrecy perpetuates myths and misconceptions, further weakening intention and informed decision-making around family planning.

**Community saliences and influences reinforce restrictive norms:** At the broader community level, collective attitudes and shared beliefs strongly shape family planning intentions and behaviors. Social approval is often tied to larger families, male children, and adherence to traditional roles, with community gossip and indirect social policing reinforcing these expectations. Myths, supernatural beliefs, and misinterpretations of religious teachings circulate widely, sustaining stigma against contraception, particularly for young couples and women seeking to limit births. Community silence around reproductive issues, combined with widespread provider bias and disrespectful care, further signals to families that family planning is neither typical nor socially endorsed, dampening both male and female willingness to pursue it.

## 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/RMNCH, 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. A high-level systems overview is presented followed by a description of critical factors at Structural and Policy levels, as well as Institutional levels which affect implementation of effective FP/RMNCH programs, with a close focus on relevance to SBC.

## Family Planning in Sindh – Policy & Systems Context

The GoS is committed to achieving universal access to reproductive health and to raise CPR from 30% to 47% by 2025 and to 57% by 2030.

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

female motivators. Since 2023 the PWD has led the development of the Male and Media Engagement Strategies for Family Planning in Sindh and has constituted a Sub-Group for SBC under the leadership of the Technical Advisor and Focal Personal for FP2030. to advance collaborative planning and advancement of SBC initiatives in the province.

The **Department of Health** (DoH) has a greater reach through its extensive network of health facilities at different levels including dispensaries, Basic Health Units (BHUs), Rural Health Centers (RHCs), Tehsil Headquarters Hospitals (THQs), and District Headquarters Hospitals (DHQs). Also operating under the Lady Health Worker (LHW) Program there is dynamic cadre of Lady Health Workers (LHWs) and Lady Health Supervisors (LHSs). In covered areas, LHWs are still the first line of information for healthcare. However, due to 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. A key partner for the DoH in Sindh is PPHI Sindh which manages and operates large proportion of the PHC system, providing high quality FP/RMNCH services including PpFP.

Sindh's adoption of the **Essential Package of Health Services** (EPHS) signals a powerful shift toward Universal Health Coverage (UHC) and a strengthened primary health care system. Building on Pakistan's national UHC framework, Sindh has tailored a provincial package of 94 interventions focused on primary care delivery through community and health centers to expand essential services and reduce out-of-pocket spending. The pilot in Tando Allahyar, covering 62 priority interventions, underscores Sindh's serious political and administrative commitment to UHC. Guided by the Department of Health and its high-level steering committee, and supported by partners like Aga Khan University, this effort marks a critical opportunity to advance systemic change through a data-driven, collaborative approach that embeds social and behavior change and integrates family planning within the EPHS rollout.

## Structural and Policy Level Factors

There are many factors at the structural and policy level that contribute to the stalled progress. Many of these are common across the provinces because of the way population is measured and factored in for resource and power sharing formulas in the country. These include the following:

**Weak Ecosystem for the Study and Practice of SBC in Sindh and Pakistan:** Social and Behavior Change (SBC) is a recognized high-impact practice (HIP) for Family Planning (FP) and Reproductive, Maternal, Newborn, and Child Health (RMNCH) interventions. However, its academic and practical application in Pakistan remains underdeveloped due to systemic challenges. The field, which draws from behavioral science, public health, sociology, psychology, anthropology, and mass communication, lacks structured, research-based curricula tailored to local contexts. This gap is exacerbated by low demand, a shortage of qualified faculty, and a limited pool of interdisciplinary SBC experts with experience in documenting behavior change interventions. The absence of dedicated technical positions and non-lapsable budgets at national and provincial levels further undermines SBC integration within the health system. Additionally, data limitations, bureaucratic barriers to primary research, and reliance on donor-funded projects contribute to weak institutionalization and

unsustainable interventions. While SBC evolves rapidly in global settings, Pakistan lags due to inadequate training opportunities and limited access to international knowledge networks. Moreover, existing reporting frameworks rely heavily on quantitative metrics, failing to capture the nuanced impacts of SBC interventions. Academic institutions largely overlook SBC, leaving a fragmented professional community with minimal collaboration for knowledge generation. Addressing these challenges requires systemic reforms, including sustained investment, interdisciplinary training, and a stronger emphasis on qualitative and theory-driven evaluation methodologies.

**An Unseen Emergency owing to Lack of Data and Reporting:** Pakistan faces significant challenges in population data collection, limiting effective policy planning and the implementation of Social and Behavior Change (SBC) interventions. The inconsistent and delayed availability of demographic data hampers the country's ability to monitor growth trends, assess fertility and contraceptive prevalence rates, and make timely adjustments. Despite recognition of these gaps by federal and provincial governments, no structured mechanism exists for annual progress tracking.

The country relies on five-yearly Demographic and Health Surveys (PDHS), which, due to their infrequency, fail to support timely course corrections. For example, the last PDHS (2017–18) remains the most recent dataset, leaving policymakers without updated insights for six years. Similarly, national censuses are often delayed due to political and logistical challenges, with the 2017 census conducted after a decade-long gap. The absence of real-time monitoring mechanisms widens the disconnect between policy intentions and on-ground realities, restricting effective planning at all administrative levels. The lack of qualitative data further compounds this issue, as household decisions on family planning, health, and gender are often assessed using anecdotal evidence or small-scale studies that do not adequately inform national and sub-national planning. To bridge this gap, Pakistan must establish dedicated population data units at the provincial level, integrating demographic surveillance with qualitative and behavioral insights. These units should prioritize real-time, cost-effective data collection methods over infrequent, resource-intensive surveys, ensuring timely and evidence-based decision-making for SBC interventions in population and health sectors.

## OVERVIEW OF KEY ENABLING FACTORS

### STRUCTURAL & POLICY LEVELS

- ▼ Poor awareness of legislative provisions and legal mandates under supportive laws leaves communities and providers uninformed about reproductive rights and protections that could advance family planning uptake.
- ▼ Weak ecosystem for SBC research and practice, including limited availability of SBC expertise, hampers the development of locally tailored, evidence-based interventions to influence key FP and reproductive health behaviors.
- ▼ Funding constraints and competing priorities for FP and SBC prevent sustained investments needed to scale high-impact interventions and build robust program infrastructure.
- ▼ Lack of data and fragmented stewardship mechanisms, driven by resource constraints, undermine efforts to coordinate, monitor, and improve the synergy and quality of SBC investments across the province.

**From resource constraint to resource optimization for Health and Population:** Sindh has demonstrated significant progress in health and population funding, increasing its health budget from PKR 4.34 billion in 2010 to a proposed PKR 300 billion for 2024–25. This substantial increase reflects a stronger commitment to public health. However, budget allocation alone is insufficient; effective expenditure remains a critical challenge. As seen at both federal and provincial levels, the majority of health funding is directed toward curative care, with primary healthcare—serving 80% of the population, receiving disproportionately low investment. For instance, in 2019–20, only PKR 4.23 billion out of PKR 80.76 billion was allocated to the Population Welfare Department.

Similarly, SBC interventions face funding constraints, as government support remains limited and donor contributions are often time-bound, making long-term program sustainability difficult. A strategic analysis of the 2024–25 health budget is essential to determine the share allocated to SBC, family planning, and primary healthcare. Linking financial planning to targeted solutions, such as capacity development of health workers, health promotion, procurement of essential supplies and contraceptives, expansion of health coverage, and quality improvement in health and FP services, can ensure that Sindh’s financial investments translate into measurable improvements in public health outcomes.

**Weak Implementation of legislative provisions which address social norms:** The province of Sindh has three legislative provisions guiding mandates for FP and RH QoC landscape. These include the Sindh Reproductive Healthcare Rights Act 2019<sup>2</sup> and its amendment in 2022, the Sindh Child Marriages Restraint Act 2013<sup>3</sup>, and the Sindh Health Care Commission Act 2013. These have not been fully implemented or integrated into the health system and have not been a part of the SBC program efforts for shifting social and gender norms. Community engagement and dissemination of knowledge and awareness of legal mandates pertaining to rights and autonomy of citizens of Sindh is hitherto missing and requires focus.

<sup>2</sup> The Sindh Reproductive Healthcare Rights Act (2019) Provincial Assembly of Sindh. Available at: <http://pas.gov.pk/index.php/acts/details/en/32/429>

<sup>3</sup> The Sindh Child Marriages Restraint Bill (2013). Available at: <http://sindhlaws.gov.pk/setup/publications/PUB-13-000734.pdf>

## Institutional Level Factors

**Youth Inclusion in RMNCH and FP:** Sindh's youthful population, 56.3 million in 2022, projected to reach 95.7 million by 2050, presents both opportunities and challenges for RMNCH and FP. With 56% of the population aged 15–64 and 27% aged 6–14, investing in youth health, education, and FP is essential. Expanding RMNCH services to meet growing demand will be critical in reducing unintended pregnancies and ensuring long-term economic benefits.

**Integrating Health and Population Services:** Stronger integration between the Population Welfare and Health Departments is essential for scaling up FP and maternal health services. Sindh's high population growth rate strains healthcare resources, while limited FP access exacerbates maternal and child health challenges. Coordinated efforts can improve resource allocation, outreach, and service delivery. Given Sindh's leadership in implementing the Costed Implementation Plan (CIP), it is well-positioned to formally integrate FP and primary healthcare services under a unified structure, ensuring sustainability and efficiency.

**Gaps in High-Quality FP Services:** Quality management and feedback mechanisms in FP services remain underdeveloped, particularly in the private sector. The 2017–18 PDHS revealed that while the public and private sectors contribute almost equally to modern contraceptive provision (44% and 43%, respectively), service quality is significantly lower in the private sector. Only 19% of women received complete information on method use and side effects, with public sector users (26%) better informed than private sector users (9%). Counseling is also stronger in the public sector, where 44% of users received guidance compared to 29% in the private sector. Lady Health Workers play a crucial role in bridging these gaps, particularly in underserved areas.

## OVERVIEW OF KEY ENABLING FACTORS

### INSTITUTIONAL LEVEL

- ▼ Limited availability and uneven reach of family planning services restrict access for rural, low-income, and young populations, leaving many without reliable options close to home.
- ▼ Poor quality of clinical care undermines trust and effectiveness, with many women receiving inadequate counseling on method use and side effects, particularly in private facilities.
- ▼ Weak counseling skills among providers and absence of structured VCAT interventions allow personal biases and harmful norms to persist, reducing the quality of person-centered, respectful care.
- ▼ Outdated training programs and insufficient quality improvement systems fail to equip health workers with the competencies needed to deliver gender-sensitive, youth-responsive family planning services.
- ▼ Lack of evidence-based, community-led initiatives to drive awareness, normalize healthy behaviors, or create peer support for FP/RMNCH.
- ▼ Minimal meaningful engagement of men and communities beyond one-off events limits opportunities to shift household decision-making dynamics and reinforce supportive norms for contraceptive use.
- ▼ Weak and inconsistent media engagement misses the chance to build widespread understanding of population issues, promote positive gender norms, and counter myths around family planning.

A significant unmet need exists for postpartum and post-abortion FP services. Postpartum FP (PPFP) is essential for reducing maternal and neonatal mortality, yet routine FP counseling during antenatal and postpartum care remains inconsistent. Expanding FP services across all maternal care facilities—including antenatal clinics, birthing centers, and postnatal care units—can improve access and reduce reliance on abortion, which has doubled in prevalence from 27 per 1,000 women in 2002 to 50 per 1,000 in 2012, with higher rates in Sindh and Balochistan.

**Fragmented Donor and Private Sector Efforts:** Sindh benefits from a strong donor landscape supporting FP and reproductive health. Key initiatives include:

- ▼ The World Bank's \$200 million Sindh Integrated Health and Population Project (2023–2027), improving RMNCH services.
- ▼ ADB and the Gates Foundation, focusing on technical assistance and accountability.

Sindh's private sector, particularly in Karachi, also plays a significant role in FP services. However, donor and private sector initiatives often lack synergy, leading to fragmented efforts. Strengthening coordination among stakeholders is crucial for maximizing impact.

**Resource Allocation and Institutional Mechanisms for SBC in Sindh:** Sindh has led family planning (FP) efforts through key institutional reforms, including the FP2030 Costed Implementation Plan (CIP), which established a dedicated sub-group for Social and Behavior Change (SBC). However, SBC remains an under-prioritized area within government structures. To institutionalize SBC, Sindh needs a comprehensive strategy, an implementation plan, and a dedicated budget.

# ANNEX 2: AUDIENCE ANALYSIS MATRIX

Specific Audience	Key Beliefs/Attitudes	Current Behaviors	Priority Behaviors	Behavioral Drivers		Preferred Communication Channels	Recommended SBC Intervention Approach
				Barriers to Priority Behaviors	Facilitators to Priority Behaviors		
MWRAS	<ul style="list-style-type: none"> <li>• Fear of side effects of modern FP</li> <li>• May view early births as culturally expected</li> <li>• Desire healthy children but may feel powerless in decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Low uptake of modern contraceptives</li> <li>• Inconsistent ANC/postnatal visits</li> <li>• Limited spousal dialogue on spacing</li> </ul>	<ul style="list-style-type: none"> <li>• Delaying 1st Pregnancy</li> <li>• Increasing Birth Spacing</li> <li>• Adopting PAFP/PPFP</li> <li>• Increasing Breastfeeding</li> <li>• Improving Child Immunization &amp; WASH</li> <li>• Fostering Interspousal communication</li> <li>• Informed Choice</li> </ul>	<ul style="list-style-type: none"> <li>• Low autonomy in patriarchal households (Social/Structural)</li> <li>• Limited negotiation skills (Intrapersonal)</li> <li>• Myths &amp; misinformation about FP side effects (Psychological)</li> <li>• Family pressure to prove fertility (Social Norms)</li> </ul>	<ul style="list-style-type: none"> <li>• She feels confident in using skilled FP/RMNCH care.</li> <li>• She believes using skilled care improves health.</li> <li>• She trusts modern FP methods to be safe &amp; effective.</li> <li>• She recognizes the risks, harms &amp; healthcare costs of not using FP/RMNCH care.</li> <li>• She believes peers in her community also use skilled FP/RMNCH care.</li> <li>• She believes her husband will support her for skilled care.</li> <li>• She perceives no major barriers to using skilled FP/RMNCH.</li> <li>• She feels confident in accessing FP/RMNCH services in terms of approval, money and transport.</li> <li>• She has knowledge and skills to access FP/RMNCH information, products, and services for target behavior.</li> <li>• She can travel to the health facility, pay for services, and ensure respectful, gender-sensitive care.</li> <li>• She frequently receives reminders through targeted interventions to use referrals.</li> <li>• She receives peer support &amp; accurate information.</li> <li>• She received positive spousal involvement reduces fear</li> </ul>	<ul style="list-style-type: none"> <li>• LHW household visits</li> <li>• Peer groups or women's clubs</li> <li>• Small-group counseling in local centers</li> <li>• Phone-based messaging for repeated reminders</li> </ul>	<ul style="list-style-type: none"> <li>• Household visits</li> <li>• Newlywed orientation sessions</li> <li>• Antenatal visits</li> <li>• Postpartum visits</li> <li>• mEALTH &amp; Digital Engagement</li> <li>• Community based post-partum support groups</li> </ul>
				<ul style="list-style-type: none"> <li>• Low autonomy in patriarchal households (Social/Structural)</li> <li>• Limited negotiation skills (Intrapersonal)</li> <li>• Myths &amp; misinformation about FP side effects (Psychological)</li> <li>• Family pressure to prove fertility (Social Norms)</li> </ul>	<ul style="list-style-type: none"> <li>• She feels confident in using skilled FP/RMNCH care.</li> <li>• She believes using skilled care improves health.</li> <li>• She trusts modern FP methods to be safe &amp; effective.</li> <li>• She recognizes the risks, harms &amp; healthcare costs of not using FP/RMNCH care.</li> <li>• She believes peers in her community also use skilled FP/RMNCH care.</li> <li>• She believes her husband will support her for skilled care.</li> <li>• She perceives no major barriers to using skilled FP/RMNCH.</li> <li>• She feels confident in accessing FP/RMNCH services in terms of approval, money and transport.</li> <li>• She has knowledge and skills to access FP/RMNCH information, products, and services for target behavior.</li> <li>• She can travel to the health facility, pay for services, and ensure respectful, gender-sensitive care.</li> <li>• She frequently receives reminders through targeted interventions to use referrals.</li> <li>• She receives peer support &amp; accurate information.</li> <li>• She received positive spousal involvement reduces fear</li> </ul>		

Specific Audience	Key Beliefs/Attitudes	Current Behaviors	Priority Behaviors	Behavioral Drivers		Preferred Communication Channels	Recommended SBC Intervention Approach
				Barriers to Priority Behaviors	Facilitators to Priority Behaviors		
<b>Adolescent Girls and Youth</b>	<ul style="list-style-type: none"> <li>• May view marriage before 18 as inevitable or “normal”</li> <li>• Limited SRH knowledge; fear social judgment</li> <li>• Rely on informal / inauthentic sources of information</li> </ul>	<ul style="list-style-type: none"> <li>• Early marriage, early childbearing</li> <li>• Minimal use of adolescent-friendly SRH services</li> <li>• Often drop out of school due to marriage/pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Delaying 1st Pregnancy</li> <li>• Reducing teenage pregnancies and improving Adolescent SRH knowledge.</li> </ul>	<ul style="list-style-type: none"> <li>• Social norms condoning underage marriage (Community)</li> <li>• Lack of privacy or youth-friendly health facilities (Structural)</li> <li>• Limited decision-making power within families (Household)</li> </ul>	<ul style="list-style-type: none"> <li>• Aspirations for education, skills</li> <li>• Peer group influence can shift norms</li> <li>• Legal protection &amp; scholarships can provide alternatives</li> <li>• Knows where to access accurate SRH information services</li> </ul>	<ul style="list-style-type: none"> <li>• School-based SRH sessions</li> <li>• Peer clubs, social media</li> <li>• Confidential helplines for adolescents</li> </ul>	<ul style="list-style-type: none"> <li>• mHealth &amp; Digital Engagement on LSBE</li> <li>• Peer Networks</li> <li>• Community Dialogues</li> <li>• Girl's clubs and vocational programs</li> </ul>
<b>Expectant &amp; New Mothers</b>	<ul style="list-style-type: none"> <li>• Some believe exclusive breastfeeding is insufficient, turning to pre-lacteal feeds early</li> <li>• May be unaware of postpartum FP benefits or immunization schedules</li> </ul>	<ul style="list-style-type: none"> <li>• Lower rates of postnatal care</li> <li>• Irregular postpartum checkups &amp; immunization follow-ups</li> <li>• May rely on mother-in-law to make child health decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Increasing birth spacing</li> <li>• Increasing breastfeeding</li> <li>• Improving child immunization and WASH behaviors</li> <li>• Adopting PAFF/PPFP</li> <li>• Fostering Interspousal communication</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate postpartum counseling at facilities (Service)</li> <li>• Fear or ignorance about postpartum contraception (Psychological)</li> <li>• Societal pressure to conceive again soon (Normative)</li> </ul>	<ul style="list-style-type: none"> <li>• Strong desire to protect newborn</li> <li>• Trusted local LHW or midwife can guide</li> <li>• Visible benefits of early checkups to detect complications</li> </ul>	<ul style="list-style-type: none"> <li>• Facility-based postpartum counseling</li> <li>• LHW postpartum home visits</li> <li>• Involvement of husbands &amp; MIL for family support</li> </ul>	<ul style="list-style-type: none"> <li>• Postnatal Home Follow-Ups</li> <li>• Celebratory Household Events</li> </ul>
<b>MRA (Fathers and Husbands)</b>	<ul style="list-style-type: none"> <li>• Some believe FP undermines masculinity or is solely a “female matter”</li> <li>• May be open to advice if economic</li> </ul>	<ul style="list-style-type: none"> <li>• Control FP decisions and finances</li> <li>• Might not attend facility visits</li> <li>• Indifferent to postpartum follow-ups if not engaged</li> </ul>	<ul style="list-style-type: none"> <li>• Delaying 1st Pregnancy</li> <li>• Increasing Birth Spacing</li> <li>• Adopting PAFF/PPFP</li> <li>• Improving child immunization and</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural myths about male virility &amp; FP (Psychological)</li> <li>• Lack of knowledge on postpartum risks (Information)</li> <li>• Socioeconomic pressure for large families (Normative)</li> </ul>	<ul style="list-style-type: none"> <li>• Interest in reducing maternal/child health costs</li> <li>• Positive male role models can shift attitudes</li> <li>• Fatherhood pride in healthy, well-spaced children</li> <li>• Has confidence in the skilled FP/RM/NCH care wife receives</li> <li>• Improves wife's and child's health.</li> </ul>	<ul style="list-style-type: none"> <li>• Men's forums or peer groups</li> <li>• Radio talk shows or local gatherings</li> </ul>	<ul style="list-style-type: none"> <li>• Male Corners at Hospitals</li> <li>• Community based Support Groups and peer led discussions</li> </ul>

Specific Audience	Key Beliefs/Attitudes	Current Behaviors	Priority Behaviors	Behavioral Drivers		Preferred Communication Channels	Recommended SBC Intervention Approach
				Barriers to Priority Behaviors	Facilitators to Priority Behaviors		
<b>MRA (Fathers and Husbands)</b>	benefits are clear (less strain on resources)		<ul style="list-style-type: none"> <li>and WASH behaviors</li> <li>Fostering Interspousal communication</li> <li>- Informed Choice</li> </ul>		<ul style="list-style-type: none"> <li>He trusts modern FP methods to be safe &amp; effective.</li> <li>He recognizes the risks, harms &amp; healthcare costs of not using FP/RMNCH care.</li> <li>He believes peers in community also use skilled FP/RMNCH care.</li> <li>Has knowledge and skills to access FP/RMNCH information, products, and services.</li> <li>He frequently receives reminders through targeted interventions to use referrals.</li> <li>Receives peer support &amp; accurate information.</li> </ul>	<ul style="list-style-type: none"> <li>Mobile phone reminders about postpartum care &amp; immunizations</li> </ul>	<ul style="list-style-type: none"> <li>Newlywed Household Visits</li> <li>mHealth &amp; Digital Engagement</li> </ul>
	<ul style="list-style-type: none"> <li>Believe in immediate/frequent pregnancies to ensure fertility "proof"</li> <li>May mistrust "modern" methods or immunizations if rooted in older myths</li> </ul>	<ul style="list-style-type: none"> <li>Press younger women to conceive soon</li> <li>- Override decisions on PFP/PAPP</li> <li>- Sometimes discourage immunizations based on rumors</li> </ul>	<ul style="list-style-type: none"> <li>Delaying 1st Pregnancy</li> <li>Increasing Birth Spacing</li> <li>Adopting PAPP/PPFP</li> <li>Increasing Breastfeeding</li> <li>Improving Child Immunization &amp; WASH</li> <li>Fostering Interspousal communication</li> <li>Informed Choice</li> <li>Reducing teenage pregnancies and improving Adolescent SRH</li> </ul>	<ul style="list-style-type: none"> <li>Deep cultural belief in early, closely spaced pregnancies (Norms)</li> <li>Misinformation about vaccines (Health myths)</li> <li>High authority over younger women (Household power)</li> </ul>	<ul style="list-style-type: none"> <li>Pride in protecting family's well-being</li> <li>Openness to new info if approached respectfully</li> <li>Peer influence from other mothers-in-law who embraced postpartum spacing</li> </ul>	<ul style="list-style-type: none"> <li>Mother-in-Law clubs or sessions</li> <li>Community gatherings where elders talk</li> <li>Local female health workers bridging generational info gaps</li> </ul>	<ul style="list-style-type: none"> <li>Mother-in-Law (MIL) Clubs</li> <li>Celebratory Household Events</li> <li>Household Visits for elders</li> <li>Parent/elder Community dialogues</li> </ul>
<b>Mothers-in-Law &amp; Other Elder Family Members</b>							

Specific Audience	Key Beliefs/Attitudes	Current Behaviors	Priority Behaviors	Behavioral Drivers		Preferred Communication Channels	Recommended SBC Intervention Approach
				Barriers to Priority Behaviors	Facilitators to Priority Behaviors		
<b>Mothers-in-Law &amp; Other Elder Family Members</b>	<ul style="list-style-type: none"> <li>• May see large families or child marriage as traditional/culturally approved</li> <li>• Concern about community backlash if endorsing FP and immunization</li> </ul>	<ul style="list-style-type: none"> <li>• Can influence entire neighborhood if they publicly accept or reject postpartum FP, immunization, marriage age</li> <li>• Hesitant to support new norms without clarifying religious and cultural tenets</li> </ul>	<ul style="list-style-type: none"> <li>• knowledge.</li> <li>• Removing Service Barriers &amp; Expanding Coverage:</li> <li>• Address financial, transport, and stigma-related barriers to improve service access.</li> </ul>	<ul style="list-style-type: none"> <li>• Fear of community pushback (Social environment)</li> <li>• Limited exposure to health data or official policies (Information)</li> <li>• Perception that FP/immunization might conflict with religion (Attitudinal)</li> </ul>	<ul style="list-style-type: none"> <li>• High trust and moral authority among their communities</li> <li>• Clear alignment of healthy spacing/immunizations with care and well-being</li> <li>• Public recognition for supporting improvements in maternal-child health</li> </ul>		
<b>Community Leaders &amp; Opinion Leaders</b>	<ul style="list-style-type: none"> <li>• Non-standardized Counseling (provider biases)</li> <li>• Overworked</li> </ul>	<ul style="list-style-type: none"> <li>• Some deliver partial/incorrect info</li> <li>• Juggle multiple duties, limiting time</li> </ul>	<ul style="list-style-type: none"> <li>• Delaying 1st Pregnancy</li> <li>• Increasing Birth Spacing</li> <li>• Improving child immunization and WASH behaviors</li> <li>• Advocating for Policy Reform i.e. Strengthen legal and administrative framework-works to prevent Child Marriage.</li> </ul>	<ul style="list-style-type: none"> <li>• Burnout, insufficient supervision (Systemic)</li> <li>• Outdated knowledge or personal biases (Individual)</li> <li>• Weak supply chain or eLMS issues (Infrastructure)</li> </ul>	<ul style="list-style-type: none"> <li>• Positive feedback when client satisfaction improves</li> <li>• Ongoing training and supportive supervision</li> <li>• Adequate supplies/logistics enabling smooth service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Friday sermons or public gatherings</li> <li>• Tribal or communal councils</li> <li>• Local orientation sessions with health data to equip them with correct info</li> </ul>	<ul style="list-style-type: none"> <li>• Religious &amp; Tribal Leaders as CPOLs</li> <li>• Community Dialogues with data demonstrations</li> <li>• Media-Policy Summits featuring influential religious voices</li> </ul>
<b>Healthcare Providers (Facility &amp; Community)</b>			<ul style="list-style-type: none"> <li>• Adopting Postpartum PAF/PPFP</li> <li>• Encouraging Breastfeeding</li> </ul>			<ul style="list-style-type: none"> <li>• In-service trainings</li> <li>• On-the-job mentorship</li> <li>• Supportive supervision visits</li> </ul>	<ul style="list-style-type: none"> <li>• Improving, LHW training</li> <li>• Alliance with private sector led CMW programs</li> </ul>

Specific Audience	Key Beliefs/Attitudes	Current Behaviors	Priority Behaviors	Behavioral Drivers		Preferred Communication Channels	Recommended SBC Intervention Approach
				Barriers to Priority Behaviors	Facilitators to Priority Behaviors		
<b>Healthcare Providers (Facility &amp; Community)</b>	<ul style="list-style-type: none"> <li>Gatekeepers for postpartum FP counseling, immunization follow-ups</li> </ul>	<ul style="list-style-type: none"> <li>for postpartum counseling</li> <li>Inconsistent postpartum coverage &amp; stock-outs</li> </ul>	<ul style="list-style-type: none"> <li>Supporting informed choice</li> <li>Improving child immunization and wash behaviors</li> </ul>			<ul style="list-style-type: none"> <li>Performance dashboards (scorecards)</li> </ul>	<ul style="list-style-type: none"> <li>Alliance with BISP and similar program</li> <li>Social Accountability Mechanism</li> <li>PBC Counseling app to improve uptake of PAFP/PPFP</li> </ul>
	<b>Teachers, Peer Groups &amp; Local Opinion Leaders</b>	<ul style="list-style-type: none"> <li>Educators can influence adolescents' attitudes on early marriage, SRH</li> <li>Peer groups can normalize or challenge teenage pregnancy</li> <li>Opinion leaders may champion or undermine FP &amp; immunization norms</li> </ul>	<ul style="list-style-type: none"> <li>Some schools lack SRH content</li> <li>Peer groups might spread myths if misinformed</li> <li>Informal leaders vary in their own attitudes (progressive vs. conservative)</li> </ul>	<ul style="list-style-type: none"> <li>Delaying 1st Pregnancy</li> <li>Increasing Birth Spacing</li> <li>Improving child immunization and WASH behaviors</li> <li>Advocating for Policy Reform i.e. Strengthen legal and administrative framework to prevent Child Marriage.</li> <li>Reducing teenage pregnancies and improving Adolescent SRH knowledge.</li> </ul>	<ul style="list-style-type: none"> <li>Barriers:                             <ul style="list-style-type: none"> <li>Inadequate SRH curricula (Systemic)</li> <li>Peer pressure to conform to risky norms (Social)</li> <li>Lack of training or confidence for teachers to address reproductive health (Educational)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Facilitators:                             <ul style="list-style-type: none"> <li>Trusted position for educators in the community</li> <li>Youth openness to peer-led models</li> <li>Local opinion leaders often hold credibility for community announcements</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>School clubs, youth groups</li> <li>Local youth centers, radio talk shows</li> <li>Community gatherings or training events</li> </ul>

Specific Audience	Key Beliefs/ Attitudes	Current Behaviors	Priority Behaviors	Behavioral Drivers		Preferred Communication Channels	Recommended SBC Intervention Approach
				Barriers to Priority Behaviors	Facilitators to Priority Behaviors		
Policymakers & Provincial Leadership	<ul style="list-style-type: none"> <li>• Make/enforce child marriage laws, postpartum FP mandates</li> <li>• Allocate budgets, shape incentives for district-level adoption</li> </ul>	<ul style="list-style-type: none"> <li>• Partial enforcement of laws</li> <li>• Budgets often prioritize high-profile infrastructure over preventive health</li> <li>• “Optimism bias” that fertility issues can wait</li> </ul>	<ul style="list-style-type: none"> <li>• Advocating for Policy Reform i.e. Strengthen legal and administrative frameworks to prevent Child Marriage</li> <li>• Removing Service Barriers &amp; Expanding Coverage: Address financial, transport, and stigma-related barriers to improve service access.</li> <li>• Reducing teenage pregnancies and improving Adolescent SRH knowledge.</li> </ul>	<ul style="list-style-type: none"> <li>• Competing priorities for resources (Political)</li> <li>• Limited accountability for child marriage enforcement (Systemic)</li> <li>• Desire for immediate visible results over intangible preventive measures (Cultural/Political)</li> </ul>	<ul style="list-style-type: none"> <li>• Political gains from improved maternal-child health outcomes</li> <li>• Data-driven dashboards demonstrating cost-effectiveness</li> <li>• Support from media, civil society urging accountability</li> </ul>	<ul style="list-style-type: none"> <li>• Provincial assemblies, policy roundtables</li> <li>• Official notifications, budget hearings</li> <li>• Media spotlights on legislative progress</li> </ul>	<ul style="list-style-type: none"> <li>• Integrating Postpartum/immunization protocols</li> <li>• Enforcement of Child Marriage Act</li> <li>• SBC Cell with Multi-Year Mandate</li> <li>• High-Level Policy Roundtables</li> </ul>

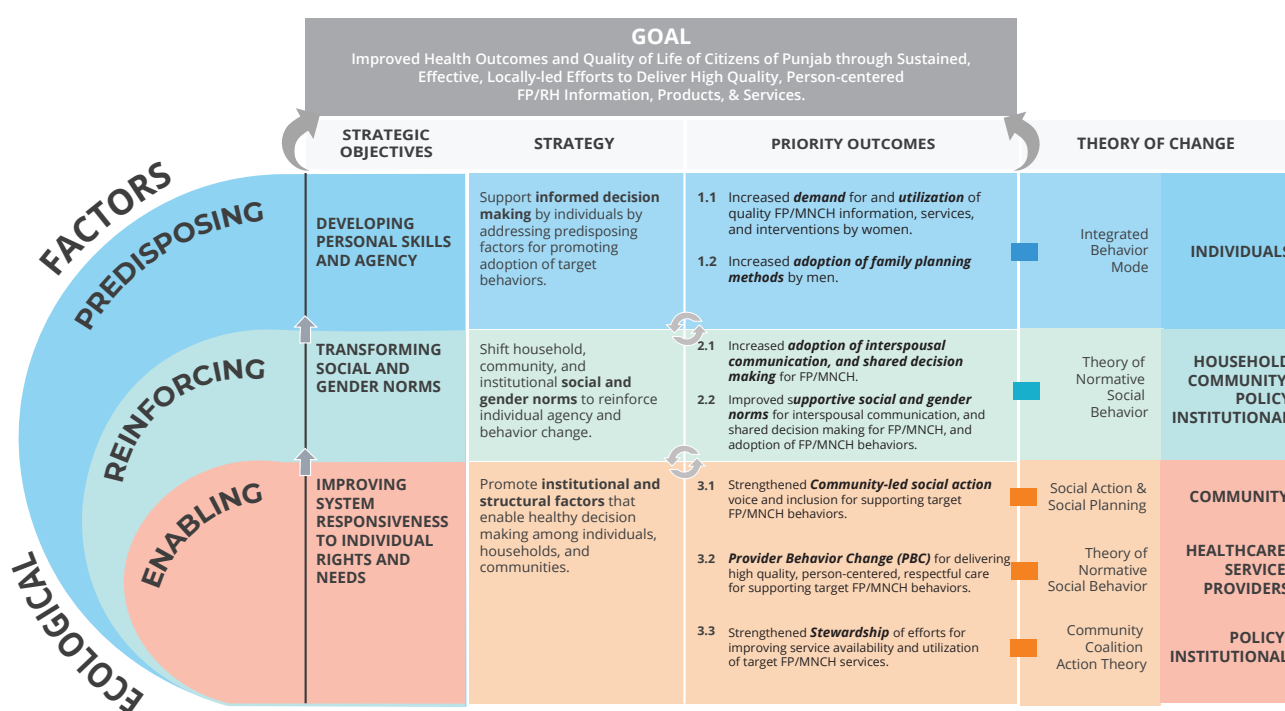
Specific Audience	Key Beliefs/Attitudes	Current Behaviors	Priority Behaviors	Behavioral Drivers		Preferred Communication Channels	Recommended SBC Intervention Approach
				Barriers to Priority Behaviors	Facilitators to Priority Behaviors		
<p><b>Media Outlets, Civil Society &amp; Social Media Influencers</b></p>	<ul style="list-style-type: none"> <li>• Amplify or distort FP/RM/NCH messages</li> <li>• CSOs track policy commitments, mobilize communities</li> <li>• Social media can shape younger audiences' norms quickly</li> </ul>	<ul style="list-style-type: none"> <li>• Sensational or inaccurate reporting can spread myths</li> <li>• Fragmented coverage or limited journalism on postpartum issues</li> <li>• Potential to push conflicting narratives</li> </ul>	<ul style="list-style-type: none"> <li>• Delaying 1st Pregnancy Birth Spacing</li> <li>• Increasing Birth Spacing</li> <li>• Improving child immunization and WASH behaviors</li> <li>• Advocating for Policy Reform i.e. Strengthen legal and administrative framework to prevent Child Marriage.</li> <li>• Reducing teenage pregnancies and improving Adolescent SRH knowledge.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of specialized health reporting knowledge</li> <li>• Fears of backlash from conservative segments</li> <li>• Unclear editorial priorities on health topics (institutional)</li> </ul>	<ul style="list-style-type: none"> <li>• Public interest in maternal-child health stories</li> <li>• CSOs' ability to gather local data and highlight gaps</li> <li>• Social media's rapid reach among adolescents/ young adults</li> </ul>	<ul style="list-style-type: none"> <li>• Health journalist trainings</li> <li>• Civil society campaigns &amp; watchdog reporting</li> <li>• Social media influencer partnerships</li> </ul>	<ul style="list-style-type: none"> <li>• Media-Policy Summits</li> <li>• Creating community champions and amplifying their voice</li> <li>• Large Scale Mass media campaigns</li> </ul>

## ANNEX 3: TECHNICAL APPROACH AND THEORETICAL UNDERPINNING

### Conceptualizing a Holistic Theory of Change

The Strategy is informed by 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 as indicated in the SBC Strategy Framework (Figure 8).

Figure 8: Sindh SBC Strategy Framework and Technical Approach



- ▶ At the individual level informed by the Integrated Behavior Model (IBM).
- ▶ For shifting social and gender norms at all levels objectives are informed by the Theory of Normative Social Behavior (TNSB).
- ▶ At the level of the community, engagement objectives are informed by the Social Planning and Social Action Model (SAPM) of community building
- ▶ 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).

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

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/RMNCH, 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 9) postulates:

**IF** SBC communication and engagement activities can create a favorable shift in individual's attitude, perceived norm, and personal agency for adopting and sustain target behavior,

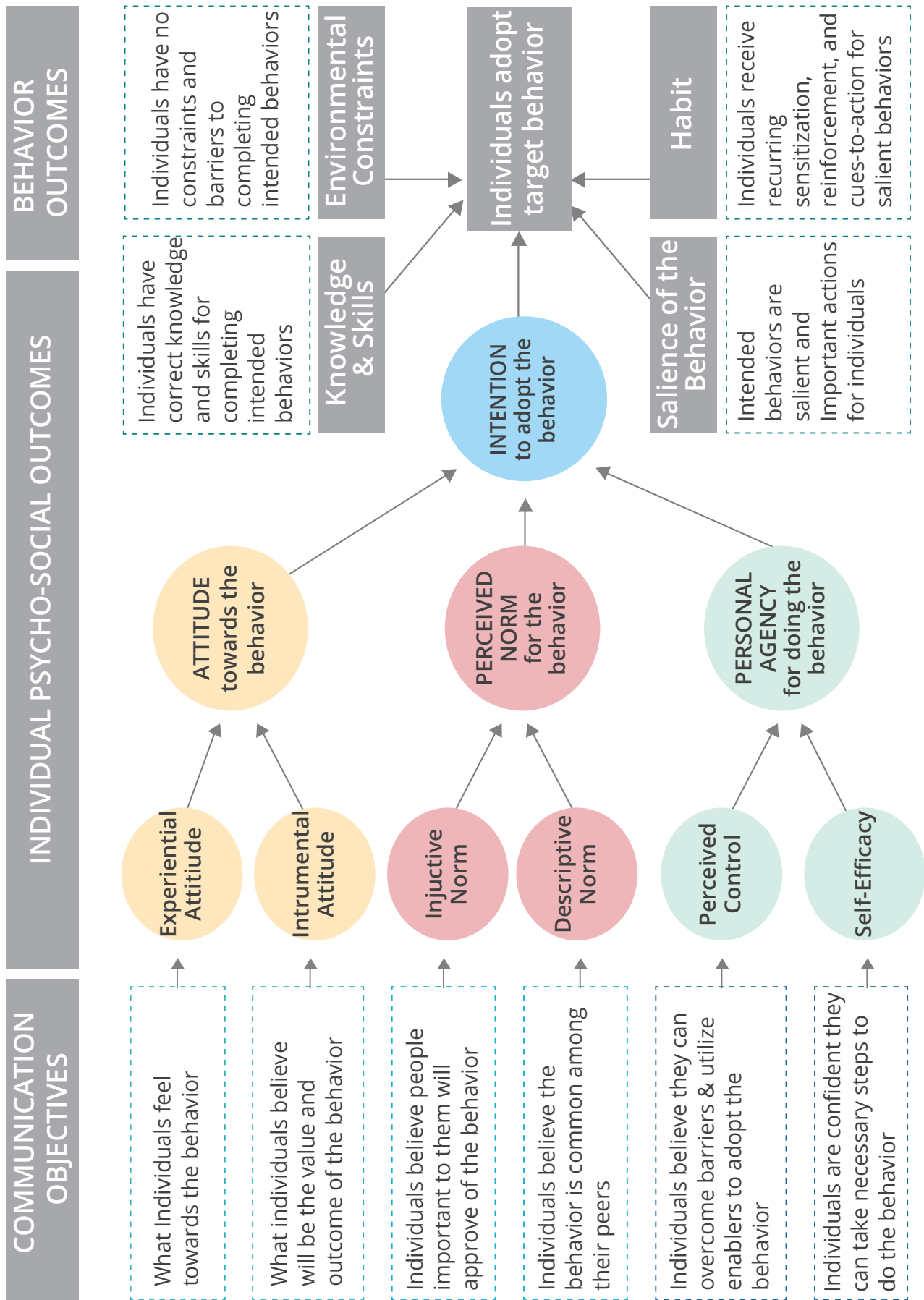
**THEN** individuals will develop intention to adopt the target behavior, and

**IF** individuals who have intention have the right knowledge and skills, do not experience significant environmental constraints, and receive cues-to-action,

**THEN** individual women and men will adopt the target behavior.

**Key concepts** described in the change hypothesis are defined by IBM and Individual-level communication and engagement objectives are described in Table 10.

Figure 9: 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**

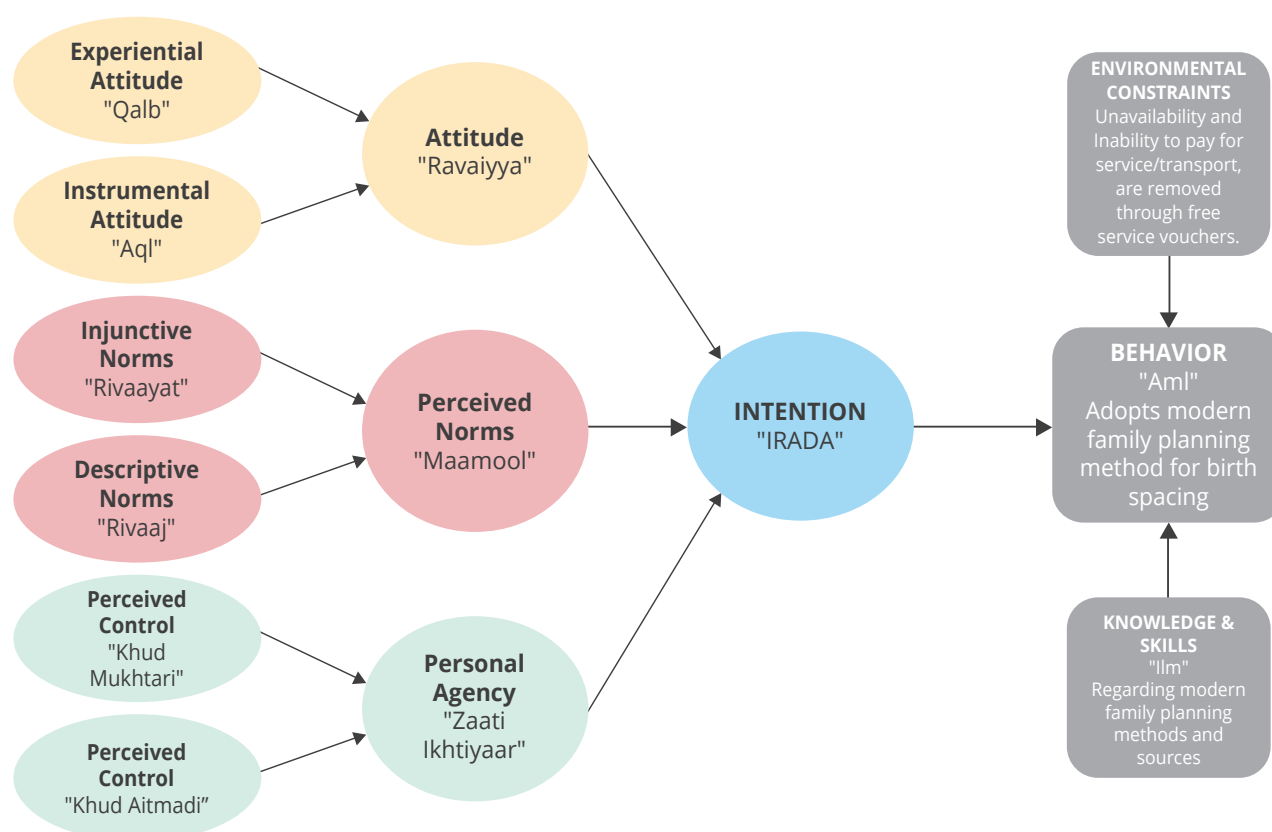
S/No.	Concept	Definition	COMMUNICATION & ENGAGEMENT OBJECTIVES
1	<b>Intention</b>	Perceived likelihood of adopting target behavior.	Individuals engaged through effective SBC messages to develop and voice intention to adopt target behaviors for FP/RMNCH.
1.1	<b>Attitude</b>	Overall affective response and cognitive evaluation of the outcomes of engaging in target behavior.	<b>Experiential attitude:</b> Individuals have favorable affective response to adoption of target behaviors for FP/RMNCH. <b>Instrumental attitude:</b> Individuals believe that adoption of target behaviors for FP/RMNCH is responsible, and wise behavior, that it is safe and effective, and will yield beneficial outcomes for them and the family.
1.2	<b>Perceived Norms</b>	Perceived expectations from peers, key influencers & observed behavior of peers and influencers related to target behavior.	<b>Injunctive norm:</b> Individuals believe that people important to them will approve of them adopting target behaviors for FP/RMNCH. <b>Descriptive norm:</b> Individuals observe their peers and influencers adopting target behaviors for FP/RMNCH
1.3	<b>Personal Agency</b>	Overall perception of ability to overcome barriers and confidence in ability to complete the target behavior.	<b>Perceived Control:</b> 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/RMNCH. <b>Self-efficacy:</b> Individuals are confident that they can take necessary steps to adopt and sustain target behaviors for FP/RMNCH.
2	<b>Knowledge &amp; Skills</b>	Overall knowledge and skills for completing target behavior.	Individuals have right knowledge, and skills for adoption of target behaviors for FP/RMNCH.
3	<b>Environmental Constraints</b>	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/RMNCH

## Establishing Cultural Congruence

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, and these have been validated conceptually and empirically through measurement (Figure 10). Building communication and engagement objectives around psychosocial concepts that translate into locally understood concepts allows the strategy to maintain cultural congruence and ensure that field staff can conceptualize these communication objectives in locally relevant terms.

**Figure 10: The IBM translated to culturally congruent concepts – The IRADA Model**



## Theory of Change for Shifting Social, Gender, and Professional Norms

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** (Figure 11) for creating favorable social and gender norms for the adoption of target health behaviors postulates:

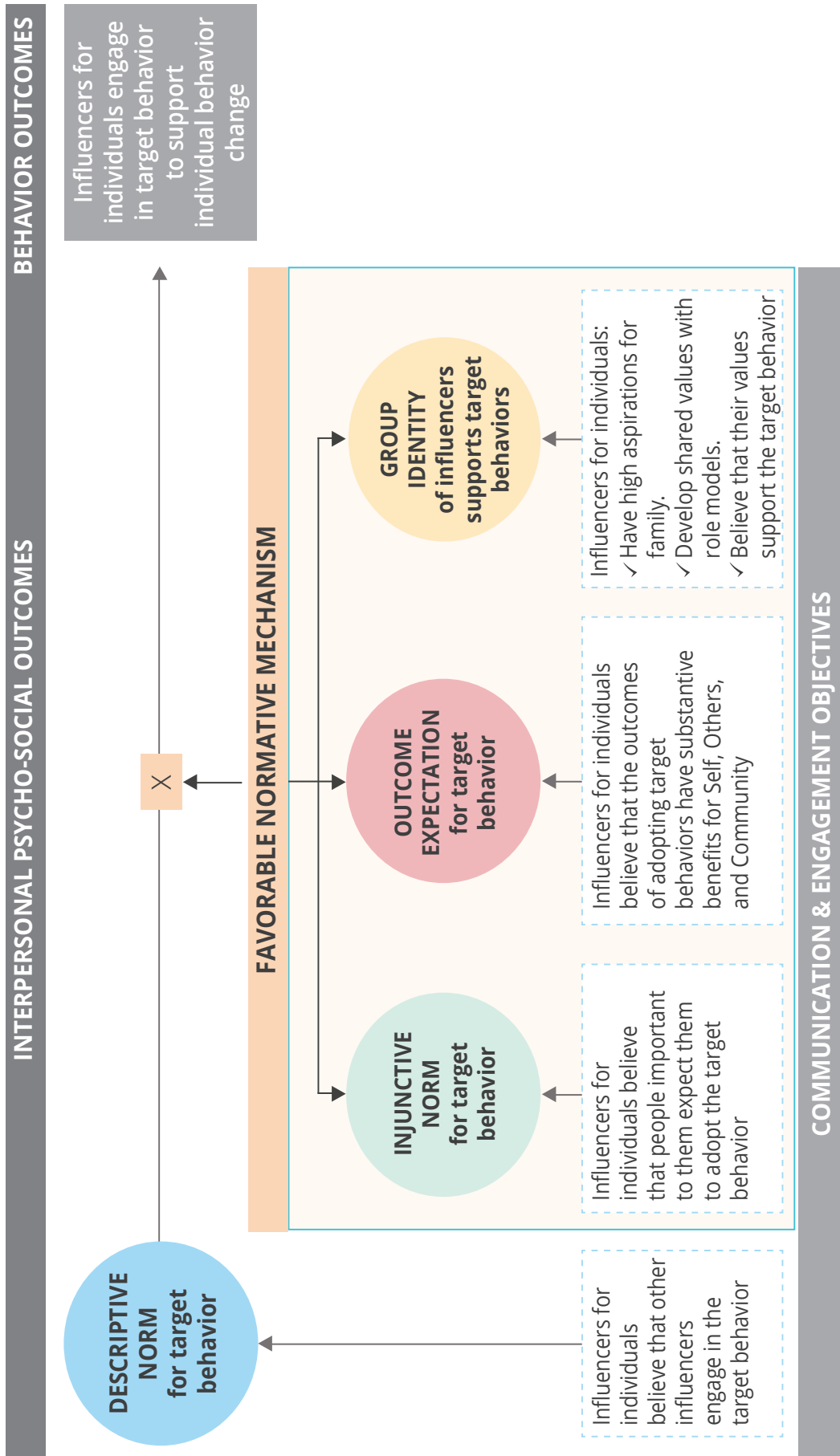
**IF** SBC communication and engagement activities can enhance descriptive norm (i.e. perceptions about how common the target behavior is among peers) for target behavior among household, community, and institutional influencers, and

**THEN** the interventional strategies create favorable normative mechanism for this behavior 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 among these influencers,

**THEN** household, community, or institutional influencers will adopt these behaviors themselves.

**Key concepts** described in the change hypothesis are defined by TNSB and inter-personal communication and engagement objectives at different levels of influence are described in Table 3. These objectives provide the framework for developing targeted and tailored key messages and informing SBC intervention design for norm shifting.

Figure 11: 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	Communication & Engagement Objectives
1	<b>Descriptive Norm</b>	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/RMNCH
2	<b>Favorable Normative Mechanism</b>		
2.1	<b>Injunctive Norm</b>	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/RMNCH is expected of them.
2.2	<b>Outcome Expectation</b>	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/RMNCH will have substantive benefits.
2.3	<b>Group Identity</b>	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/RMNCH , mental health, and cancer prevention.

## Theory of Change for Community Empowerment

Community empowerment for FP/RMNCH 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.

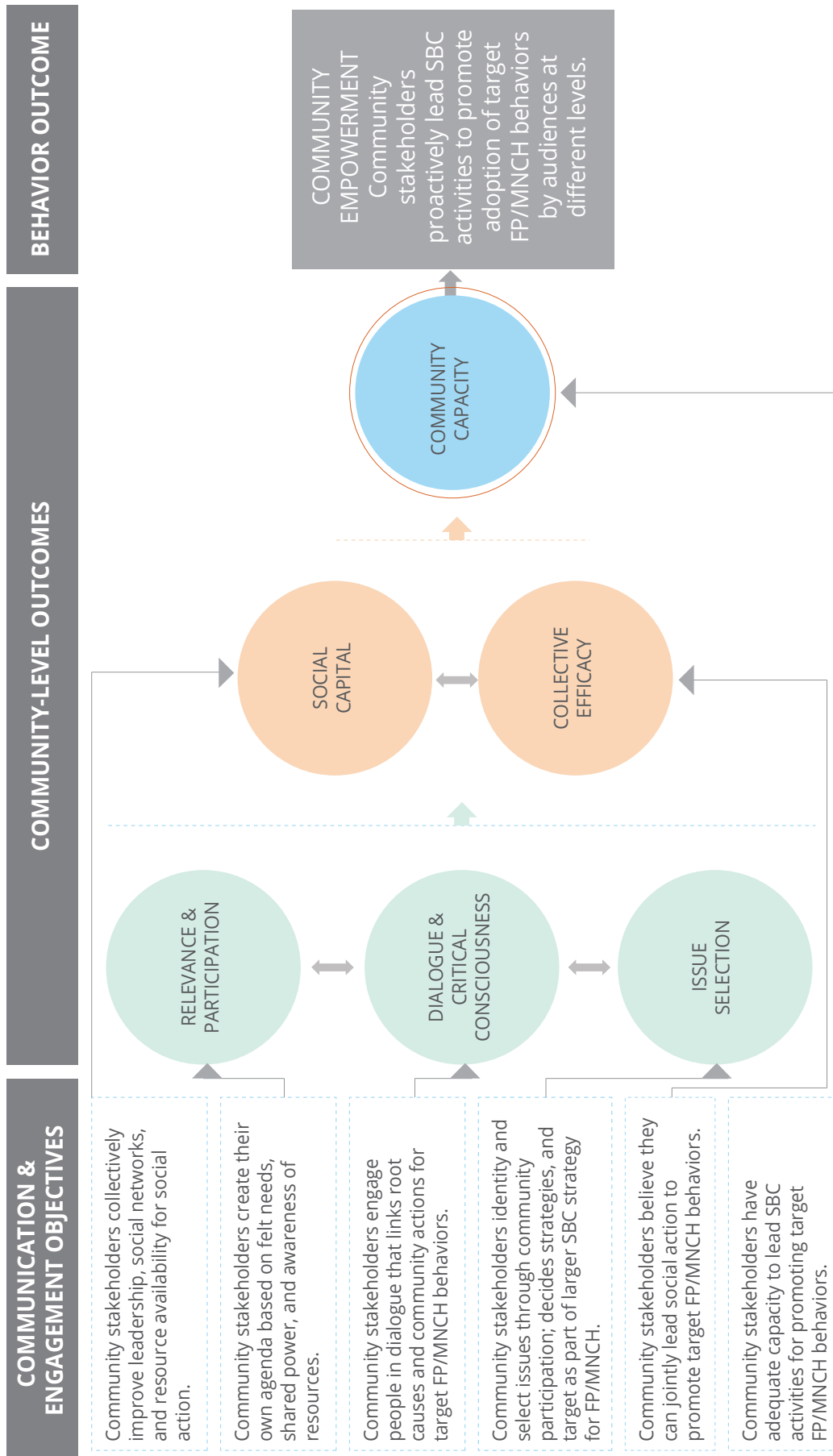
**IF** SBC activities strengthen formal and informal community platforms to facilitate community stakeholders and community groups in critical reflection, and participatory dialogue to identify and prioritize issues to address for promoting target health behaviors, and

**IF** community stakeholders and community groups are supported through needs-based capacity development to improve knowledge and skills for promoting target health behaviors,

**THEN** communities will develop social capital and collective efficacy, and community representatives will participate in public private dialogue for improved social accountability and lead community-based SBC to promote target behaviors.

**Key concepts** outlined in the community-level change hypothesis have been adapted to articulate the objectives of community mobilization, development, and engagement in support of community-led social action for FP/RMNCH SBC. These objectives serve as a guiding framework for designing and implementing community development interventions that drive the social action cycle, fostering an enabling environment for FP/RMNCH within communities. The objectives include Participation and Relevance, Critical Consciousness and Issue Selection, and Social Capital and Collective Efficacy, all of which contribute to building Community Capacity and Empowerment. Figure 12 illustrates the change pathway and anticipated outcomes, with detailed definitions provided in Table 12.

Figure 12: Theory of Change: Community empowerment and social action



## 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/RMNCH 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/RMNCH in communities across the Sindh.

**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	<b>Empowerment</b>	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/RMNCH services by individuals.
2	<b>Community Capacity</b>	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/RMNCH services and become better able to address future problems collaboratively.
3	<b>Collective Efficacy</b>	Community level perceptions of perception 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/RMNCH services.
4	<b>Social Capital</b>	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/RMNCH services.
5	<b>Issue Selection</b>	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/RMNCH services.
6	<b>Critical Consciousness</b>	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 of FP/RMNCH services.





