

**गर्भवती महिला का देखभाल**

33

यौनसंयम आहार व्यवहार ही अच्छी, स्वस्थ संतानों का सुदूर बच्चा।

**प्रतिदिन अन्न**

अन्न की 1/2 मात्रा

- 1- कन्दना सिंह सैनी (आ. क.)
- 2- सतीश सिंह सैनी (आ. क.)
- 3- प्रमिता बग्गी (आ. क.)

विकास खण्ड - फरीदपुर (बैठक)  
जिला जालंधर

**गर्भवती महिला की देखभाल**

प्रतिदिन अन्न

अन्न की 1/2 मात्रा

3 घण्टे दिन में आराम, केवल कोई भारी काम।

**गर्भवती महिला का देखभाल**

प्रतिदिन अन्न

अन्न की 1/2 मात्रा

3 घण्टे दिन में आराम, केवल कोई भारी काम।






## Foreword

Behaviour Change Communication (BCC) is one of the core strategies outlined in state NRHM PIP to achieve the goals of reduction in mortality, fertility and morbidity in Uttar Pradesh. Gaps in BCC conceptualization, planning and implementation have resulted in sub-optimal effectiveness of various health communication initiatives. Given this backdrop, the importance and timeliness of the Uttar Pradesh NRHM BCC Strategic Plan can hardly be underscored.

The UP NRHM BCC strategy document has a clearly defined focus on behaviour change, an evidence-based barriers analysis and it outlines a list of priority behaviours across the spectrum of NRHM programmes. It also provides equal impetus and focus to grassroots and community level BCC activities in addition to mass media campaigns. The document is supported by details of the operational aspects of programme implementation such as role definition, supervision, monitoring; and standard guidelines for implementing BCC activities.

Capacity to plan, monitor and implement BCC programmes will have to be built at state, district, block and village levels. This poses an enormous challenge. The NRHM BCC strategy document provides a blueprint to initiate the process of developing BCC capacity.

The process of development of the strategy document has been highly participatory. As a result the document has been enriched by a variety of inputs, insights and suggestions. We are confident that sincere and sustained implementation of this strategy will significantly improve the effectiveness of various initiatives being undertaken through NRHM in the state.



(Rajeev Kapoor)  
Secretary Health & Family Welfare  
Government of Uttar Pradesh,  
Mission Director, NRHM &  
Executive Director, SIFPSA

20<sup>th</sup> November 2008,  
Lucknow



---

## Acknowledgements

A comprehensive BCC strategy including a detailed implementation plan for all the NRHM activities has been prepared as a part of the approved program of implementation for NRHM in the state for 2008-2009. This work has been supported by USAID through SIFPSA and IFPS II Technical Assistance Project (ITAP).

I would like to acknowledge the authorship of this document of Nandita Kapadia Kundu PhD, Consultant supported by Geetali Trivedi, Senior Program Officer of the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP). Both are to be commended for taking up the challenging task of developing a comprehensive strategy for NRHM and developing this blueprint for BCC efforts in the state. This strategy will have a tremendous impact on implementation of the NRHM in the state.


I would also like to acknowledge the support by Neill Mckee, Regional Director Asia and Shailaja Maru, Program Officer, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP) Baltimore, Dr. G. Narayana, Country Director, Futures Group International, Shuvi Sharma, Manager Social Marketing & Franchising, ITAP, for the development of the strategy.

The Core group that oversaw the development process and reviewed the strategy had representation from the NRHM Directorate, SIHFW, UPSACS, UNICEF, PATH, JHSPH and Mahila Samkhaya. The collective experience of the core group has added to the strategy's depth and detail. I would like to thank all the members of the Core Group for all their suggestions, comments and recommendations and especially Dr. M.K.Sinha, General Manager SIFPSA, who painstakingly coordinated the Core Group and was instrumental in the development process.

I would also like to acknowledge the reviewers of the strategy from USAID, ITAP, Vistaar & UNICEF who took the time to give their suggestions for finalizing the BCC strategy for Uttar Pradesh.

We received constant encouragement and guidance from Government of India, during the process of strategy development and we are grateful for their support and guidance.

Finally, this work would not have been possible but for the guidance and leadership provided by Ms. Nita Chowdhary, Principal Secretary, Department of Health & Family Welfare, Government of Uttar Pradesh.

  
(Rajeev Kapoor)  
Secretary Health & Family Welfare  
Government of Uttar Pradesh,  
Mission Director, NRHM &  
Executive Director, SIFPSA

20<sup>th</sup> November 2008,  
Lucknow

## Contents

<b>Part I: BCC Strategy</b>		<b>Pages</b>
	Executive Summary	5
<b>Chapter 1</b>	Introduction	8
<b>Chapter 2</b>	Situational Analysis	13
<b>Chapter 3</b>	<b>NRHM BCC Strategy:</b> Selection of Priority Behaviours & BCC Barriers Analysis	23
<b>Chapter 4</b>	<b>NRHM BCC Strategy:</b> Overarching Strategy, BCC Interventions & Innovations	31
<b>Chapter 5</b>	Immediate Short Term BCC Strategic Plan	63
<b>Part II: Operational aspects of the NRHM BCC plan for Uttar Pradesh</b>		
<b>Chapter 6</b>	<b>Long Term Plan:</b> State Level BCC Tasks & Responsibilities	71
<b>Chapter 7</b>	<b>Long Term Plan:</b> District and Block Level BCC Tasks & Responsibilities	78
<b>Chapter 8</b>	<b>BCC Guidelines for Implementation:</b> IPC, Community Based BCC Activities & Outreach Services, Mass Media	84
<b>Chapter 9</b>	Building BCC Capacity	92
<b>Chapter 10</b>	Supportive Supervision, Monitoring and Evaluation	96
<b>Chapter 11</b>	Recommendations and Conclusions	101
<b>Annexure 1</b>	Conceptual Framework	103
<b>Annexure 2</b>	Continuum of Care Packages for MNCH	108
<b>Annexure 3</b>	List of Stakeholder Interviews; Core Group Members, Reviewers	109
<b>Annexure 4</b>	District Level Infant Mortality Analysis for Uttar Pradesh (2001 Census Data)	113
<b>Annexure 5</b>	NRHM Priority Behaviours (for 10 Health Areas)	114
<b>Annexure 6</b>	Modified BCC Log Frames	115
<b>Annexure 7</b>	One Year Strategy for Group Meetings by ASHA	128
<b>Annexure 8</b>	One Year Strategy for Group Meetings by ANM	130
<b>Annexure 9</b>	Information Required for a District BCC Plan	132
<b>Annexure 10</b>	8 Day BCC Course for Block BCC Officers	136
<b>Annexure 11</b>	One Year Gantt Charts for NRHM BCC Strategy	140
	Bibliography	149

---

## Glossary

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
<i>Badhai</i>	ongratulations
<i>Bal Chetak</i>	Child volunteer
<i>Bindi</i>	Coloured dot on forehead of many Indian women
BCC	Behaviour Change Communication
Crore	Ten million
DHEIO	District Health Education and Information Officer
DOTS	Directly Observed Treatment
ICDS	Integrated Child Development Scheme
IEC	Information Education Communication
IPC	Interpersonal Communication
IUD	Intrauterine device
JSY	Janani Suraksha Yojna (Safe Motherhood Scheme)
LFA	Logical Framework Analysis
NRHM	National Rural Health Mission
NSV	Non scalpel vasectomy
MPW	Male Multipurpose Worker
PHC	Primary Health Centre
<i>Puniya</i>	Spiritual merit
RI	Routine Immunization
<i>Sadharanikaran</i>	An ancient theory of communication
<i>Sahridaya</i>	Compassion
SIFPSA	State Innovations for Family Planning Services Agency
TB	Tuberculosis
UP	Uttar Pradesh
VHND	Village Health and Nutrition Day
WCD	Women and Child Development

---

## Executive Summary

### Overview

Uttar Pradesh is one of the first states in India to initiate a state level BCC strategy for NRHM<sup>1</sup>. This BCC strategy document intends to provide a blueprint for focussed BCC interventions to achieve the goals of NRHM. Towards this end, workable BCC strategies which can be integrated with on-going programs are proposed.

The BCC strategy document for NRHM for the State of Uttar Pradesh is evidence based and uses an ancient Indian theory of communication, *Sadharanikaran*, in addition to the Johns Hopkins University Centre for Communication Programs “PATHWAYS” model as its conceptual foundation. Also, it is one of the first BCC strategy documents that clearly spell out priority behaviours across the spectrum of NRHM programs. These priority behaviours are the pivot around which the communication strategy has been developed.

UP BCC strategy document seeks to address the following gaps in BCC services in the state - (1) lack of a coordinated BCC effort across and within national programs; (2) lack of decentralized BCC planning at the district, block and village levels (3) lack of behaviourally focussed, socio-culturally driven BCC approaches and (4) an excessive focus on electronic mass media.<sup>2</sup>

The NRHM BCC strategy shifts the emphasis of BCC programs from awareness to action. The focal point of BCC strategy development is analysing barriers to behaviour and behaviour change. An extensive evidence based behavioural barriers analysis for all NRHM programs was undertaken. Based on this analysis, modified BCC log frames were prepared for all the national health programs. An important aspect of the BCC log frames has been that it has addressed health service and structural barriers. BCC workload has also been calculated in the modified BCC log frames.

The BCC strategy aims at convergence of behavioural focus, associated persuasive inputs and synchronization of resources. An integrated three-year strategy at the interpersonal, community and mass media levels of communication through a “phased campaign approach” is being proposed.

The strategy aims to build on vast community based resources available in Uttar Pradesh and to build the capacity of ASHAs to be effective BCC change agents. The strategy document outlines a three point operational agenda and goes on to define the roles for the Village Health and Sanitation Committees (VHSC). Child to community approaches seeks to involve the children for mobilizing communities for the Routine Immunization programs. A “Bal Chetak” strategy in combination with a simplified colour coded “5 contact” approach will be used for increasing routine immunization (RI) coverage. The Bal Chetak strategy is based on evidence from research conducted by the Institute of Health Management, Pachod that both - the children and the community benefit by participating in community health activities as change agents.

The strategy recognizes that the role of mass media needs to be redefined given the limited reach of mass media channels in the rural Uttar Pradesh on the one hand and the increasing emergence of alternate media such as mobile phones and VCD players on the other. Approaches to extend the reach of the traditional mass media channels and to overcome the power shortages in the state have been suggested through tapping the numerous local cable networks and using electronic equipment like DVD/VCD players at the block and village levels. Innovative use of “short films/CD Spots”, portable VCD players, SMS campaigns etc. is suggested to extend the reach of electronic mass media channels. A

---

<sup>1</sup> Orissa and Chhattisgarh have BCC strategy documents for RCH 2 but their implementation has been partial. “Draft Report on Enhanced Capacity of Government Partners for BCC”. UNICEF, MSG Consultants (May 2007)

<sup>2</sup> These gaps were identified by the stakeholders interviewed during the development of the document. They also reflect the views of the team working on the BCC strategy document. The UNICEF report (2007) on “Building IEC Capacity in Government Partners” also states these concerns.

---

state level BCC resource centre is proposed that will enhance the local BCC capabilities of the districts and work with alternate media to extend reach and effectiveness of electronic media.

BCC guidelines for effective IPC, group and mass media interventions are provided in the strategy document. BCC guidelines will enable uniformity of input and are important in a field where technical capacity has to be built at all levels.

The strategy document includes a plan for capacity building. It also outlines the immediate action points to facilitate immediate implementation of the BCC strategic plan. Long term recommendations include building BCC planning, implementation and monitoring capacity at the district and block levels. The strategy document also defines the BCC input, output and outcome indicators in the section on monitoring and evaluation. Evaluation studies to scientifically assess the impact of BCC have also been proposed.

### **NRHM BCC Strategy**

Developing a comprehensive BCC strategy for all NRHM programs is a challenge. The document outlines several strategic BCC inputs:

1. A detailed BCC plan on maternal and new born health, child health and family planning.
2. A broad BCC plan for all national health programs (refer modified BCC log frames and Gantt charts).
3. BCC guidelines are provided for campaigns, group meetings and home visits can also be applied to all national programs.
4. A special campaign on prevention and management of outbreaks that involves a strong community involvement component.

### **Priority Behaviours**

Uttar Pradesh has one of the highest infant and child mortality rates in India. Infant mortality rates in UP are higher in young mothers (< 20 years) compared to women 20-29yrs. UP's maternal mortality ratio is also very high, second only to Bihar. There are stark gender differentials in the post neonatal mortality and child mortality rates in UP indicating gender bias against the girl child.

Priority trigger behaviours across all NRHM programs have been selected based on evidence of association of the behaviours to prevent outcomes such as maternal mortality, neonatal and child mortality, anaemia, TB, vector borne diseases etc. and potential for change through BCC approaches.

A core group established for providing strategic inputs for the BCC strategy identified a list of 27 important behaviours across 10 national health programs (Annexure 5); 14 priority behaviours have been further selected from these 27 behaviours.

### **Overarching NRHM BCC Strategy**

The core strategic input for the NRHM BCC strategy centres on using interpersonal communication and community level BCC activities supported by mass media and community mobilization interventions. The strategy proposes interventions at the state, facility, community and household levels. The effective implementation of the BCC strategy is dependent on partnerships, coordination and collaboration with development partners, NGOs and CBOs.

The BCC innovations proposed in the strategy document include the use of short films (CD spots), an IPC tool for home visits, the use of cell phones and SMS for increasing male involvement in maternal health, low cost cookbook with iron rich and vitamin C rich recipes; “*Shubh Vivah*” kits for married couples and “*Badhai*” kits for new borns; Bal Chetak and colour coded RI strategy and painting & colour coding of the ASHA's home, community notice boards, growth cards, report cards; *Khushali Diwas*, *Saas Bahu* Sammelans, *Swasthya Melas* etc.



---

## Recommendations

A detailed set of recommendations for operationalizing of the BCC strategy are provided in the document. Priority has been accorded to establishing the VHND and home visit strategies within the first year. Existing media campaigns such as SIFPSA's "*Suvidha*" (for IUD promotion) and Female Sterilization Campaign should be immediately run according to the campaign theme.

Capacity building efforts should include an orientation for all health care workers on the "Basics of BCC and UP's Strategic BCC Plan". Detailed plan for capacity building for effective BCC planning, implementation, supervision and monitoring is required to be worked out for the future.

District level BCC cells and a state level BCC resource centre need to be established. The innovative BCC strategies outlined in the strategy document need to be pilot tested and impact assessed before upscaling.

The National Rural Health Mission (NRHM) was launched nationwide in April 2005 with the aim of providing “integrated primary care services” to the most marginalized segments of the rural population in India. The needs of the urban poor are to be addressed through the Urban Health Mission which is slated to be launched in October, 2008. The core strategies of NRHM include community based Accredited Social Health Activist (ASHA), the establishment of Village Health and Sanitation Committees (VHSC), the enforcement of Indian Public Health Standards (IPHS) at all community health centres at the block level and convergence of health programs at the community level. The National Rural Health Mission accords priority to BCC (Behaviour Change Communication) interventions as a mechanism for achieving its goals<sup>3</sup>.

Uttar Pradesh (UP) is the most populous state in India with a population of 16.7 crores (167 million). UP’s vast population presents a challenge for the development of an effective and comprehensive BCC strategy. The State Action Plan for Uttar Pradesh (2008-2009) identifies “lack of a state specific integrated BCC strategy and implementation plan” as a key area for strategic input. It also reiterates the need to undertake regular research and evaluation studies for BCC interventions.

Uttar Pradesh is one of the first states in India to initiate the process of development of a state level comprehensive BCC strategy for NRHM<sup>4</sup>. This BCC strategy document intends to provide a blueprint for focussed BCC interventions to achieve the goals of NRHM. Towards this end, workable BCC strategies which can be integrated with on-going programs are proposed. For example, BCC inputs will be planned for the monthly Village Health and Nutrition Day (VHND), the six monthly NSV camps, the DOTS volunteers, the “child health and nutrition” months (June and December), Saas Bahu Sammelans, Routine Immunization etc.

The BCC strategy seeks to address the following gaps in BCC services in the state - (1) lack of a coordinated BCC effort across and within national programs; (2) lack of decentralized BCC planning at the district, block and village levels (3) lack of behaviourally focussed, socio-culturally driven BCC approaches and (4) an excessive focus on electronic mass media without large scale community based activities.<sup>5</sup>

Uttar Pradesh is largely rural, with a high level of non-literacy in women. In addition, only 22 percent of rural households own a TV and 28 percent have electricity (NFHS 3)<sup>6</sup>. Given this scenario, UP’s BCC

<sup>3</sup> Government of India (2005), “National Rural Health Mission 2005-2012 Mission Document”

<sup>4</sup> Orissa and Chhattisgarh have BCC strategy documents for RCH 2 but their implementation has been partial. “Draft Report on Enhanced Capacity of Government Partners for BCC”. UNICEF, MSG Consultants (May 2007)

<sup>5</sup> These gaps were identified by the stakeholders interviewed during the development of the document. They also reflect the views of the team working on the BCC strategy document. The UNICEF report (2007) on “Building IEC Capacity in Government Partners” also states these concerns.

<sup>6</sup> IIPS and Macro International (2008) “National Family Health Survey (NFHS-3), India 2005-2006: Uttar Pradesh”. Mumbai, IIPS

---

strategy focuses on community based approaches while using mass media to create an enabling environment. Community based approaches to BCC include home visits, group meetings and working with existing local structures and community groups.

In addition to community based approaches and mass media, the strategy will try to extend the reach of the electronic media through the use of alternate technologies such as compact discs (CDs) and cell phones that are increasingly available in rural Uttar Pradesh.

### Definitions of Behaviour Change Communication

A common understanding of basic concepts such as communication and behaviour change communication is required. The definition of communication used in the strategy document emphasizes the role of human interaction for “mutual understanding” or communication to occur<sup>7</sup>.

#### Communication is a process of “convergence”

“Communication is a process in which participants create and share information with one another in order to reach a mutual understanding”<sup>8</sup>.

“Mutual understanding builds the foundation for mutual agreement, which in turn makes collective action possible.... Effective communication begins with the audience and continues over time as a process of mutual understanding and convergence.”<sup>9</sup>

#### Behaviour Change Communication

BCC is a research-based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods.

Neill McKee, 2002

#### What is Behaviour Change Communication?

BCC is about changing specific behaviours – “well defined actions at the household, community and health service levels”. BCC approaches recognize that behaviour change is more about identifying the causes and barriers to behaviour change and overcoming the barriers. It is about understanding the communities, contexts and environments in which behaviours occur. BCC is also about using persuasive techniques to demand health rights and to make public sector health services available and accessible to the neediest. BCC is about integrating new practices into long standing social, cultural and communication systems.

Nandita Kapadia-Kundu, 2008<sup>11</sup>

The definition of BCC by McKee is comprehensive and includes the role of assessment and analysis to guide the development of communication strategies with a mix of different media and channels (refer box). The main difference between IEC (information education and communication) and BCC is that while IEC is more one-way and focussed on “messages”, BCC is more “outcome oriented” and also includes the role of participatory methods and motivation in the behaviour change process<sup>10</sup>.

IEC is based on the implicit assumption that awareness creation will automatically lead to behaviour change. Hence the emphasis of IEC is on “creating messages”, entertainment and media. This strategy document uses an operational definition

---

<sup>7</sup> Several stakeholders stated in their interviews that “human interaction” is necessary for behaviour change to occur.

<sup>8</sup> Kincaid, D.L. (1979) “The Convergence Model of Communication” Paper 18, Honolulu; East-West Communication Institute, East-West Centre

<sup>9</sup> Piotrow, P., Kincaid D.L., et al (1997) “Health Communication: Lessons from Family Planning and Reproductive Health” Johns Hopkins School of Public Health, Praeger Publishers

<sup>10</sup> Bertrand and Becker-Benton – Strategic Communication in the HIV/AIDS Epidemic, Sage Publication, New Delhi, 2004

of BCC that includes: (1) the need to define behavioural actions that require change, (2) to assessing the barriers to behaviour change, (3) demanding health rights and making health services available and accessible to marginalized groups and (4) using persuasive techniques to integrate new practices into existing social environments (Refer box)<sup>11</sup>.

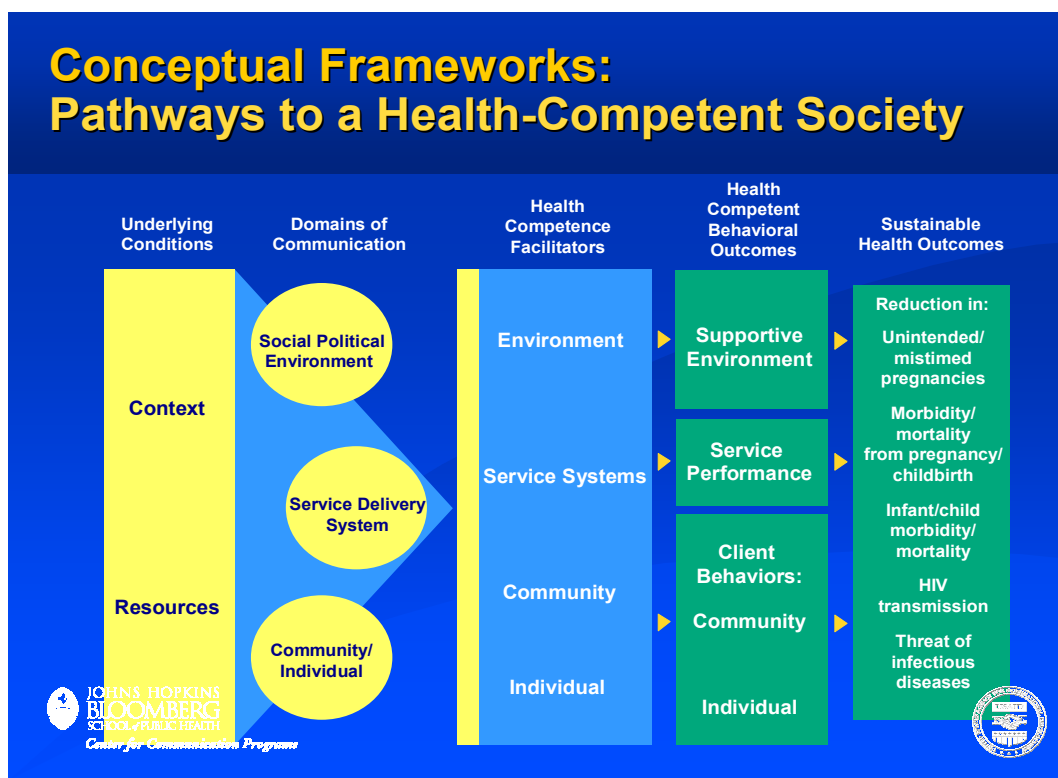
### Conceptual Framework for BCC Strategy Document

Many theories of behaviour and behaviour change exist. This strategy document uses two important models to guide the development of the NRHM BCC strategy.

The **Pathways model** provides an overall framework to consider interventions at the environmental, service delivery, community and individual levels.

**Sadharanikaran**, which is an ancient Indian theory of communication with relevance to changing health behaviours in modern India<sup>12</sup>, on the other hand enables a contextual understanding of the communication processes in India.

### Pathways Model:



The Pathways model developed by Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP) for a health competent society, widens the scope of BCC to include

<sup>11</sup> Kapadia-Kundu, N. (forthcoming) “Non-Cognitive Determinants of Behaviour Change”

<sup>12</sup> Kapadia-Kundu, N. (1994) *An empirical test of the Sadharanikaran theory of communication to defecation hygiene behaviour: An evaluation of a child-to-community intervention in Maharashtra, India. Phd Thesis submitted to the Johns Hopkins School of Hygiene and Public Health*

---

creation of a supportive environment, improved health services in addition to changing behaviours at the individual and community levels (refer Annexure 1).

### Sadharanikaran

*Sadharanikaran* is an ancient Indian theory of communication based on the second century BC treatise of dance and drama, the “*Natyashastra*”. The theory’s relevance to health behaviour and public health lies in its inclusion of communication processes central to Indian culture and society such as compassion, social influence, hierarchical patterns of communication and simplification.

*Sadharanikaran* means simplification without dilution; simplification while maintaining the essence and meaning of the content that is to be communicated. It is among the few theories of behaviour and communication that has its origins outside of Anglo-American culture, thereby providing a perspective quite different from the “cognitive-rationally” driven theories that predominate the field. *Sadharanikaran* permits us to take a new look at understanding the processes and elements of behaviour change (refer Annexure 1).

#### Application of *Sadharanikaran* Theory to the Development of the NRHM BCC Strategy

- “*Sahridaya*” (compassion) is an important step to enabling communication. “*Sahridaya*” be crucial in training health providers including ASHAs and ANMs to provide effective BCC. It can be directly used in both interpersonal contexts and modelled in mediated contexts.
- “*Saas-Bahu*” (mother-in-law and daughter-in-law) meetings can be designed to promote lateral communication instead of the existing hierarchical system (asymmetry).
- “*Sadharanikaran*” (simplification) in the colour-coded RI (routine immunization) strategy involving *Bal Chetaks*
- Social influence, an important precursor to behaviour change can be modelled in mediated contexts and can also be used in direct communication interventions such as group meetings, local events etc.
- The concept of “spiritual motivation” “*puniya*” (a well understood concept in India) can be used as a technique of persuasion; spiritual appeals can be used instead of “value-expectancy” techniques. This can be used for the provider campaign and community mobilization efforts.
- “*Khushali Diwas*” represents the “*rasa*” (emotion) principle of *Sadharanikaran*. Arousing positive emotions is necessary for persuading people.

### Continuum of Care

There is an increasing need to focus on the provision of integrated health services. The strategy document follows a “continuum of care” approach which defines a set of eight health care packages (three packages at the clinical level, four packages at the OPD or outreach level and one package at the family/community level) for maternal, newborn and child health and addresses various stages of the life cycle<sup>13</sup>. This approach provides a practical framework by defining the clinical, outreach and household levels of care. The proposed eight packages that can be adapted to differing situations and resource availabilities are outlined in Annexure 2.

This BCC strategy will focus on changing behaviours at all levels of care ranging from clinic to family and community level and proposes BCC interventions that will increase utilization of services at the outreach and primary health centre/ block PHC levels as well as to improve family and community level behaviours such as safe drinking water, personal hygiene, nutrition, clean physical environment etc.

---

<sup>13</sup> Kerber, K. et al (2007) “Continuum of care for maternal, newborn and child health: from slogan to service delivery” *Lancet*, vol. 370, Oct 13, pp 1358-1369

---

## Methodology

The BCC strategy document begins with a situational and behavioural analysis of the health scenario in Uttar Pradesh. The situational analysis includes a review of state level studies such as NFHS, the district health survey for Uttar Pradesh and micro studies conducted in various parts of the state. In addition about 24 stakeholders were interviewed to get their inputs and perspectives on the new proposed BCC strategy document (refer Annexure 3 for interview guidelines and list of interviews). A core group established to provide periodic inputs and review the BCC strategy document and met three times through the course of development (refer Annexure 3 for list of core group members).

1. An extensive literature review was undertaken to analyse the health scenario in UP and to assess behavioural barriers. The literature review included relevant papers in peer reviewed journals, various studies done in UP, state and district level health data and formative, contextual research.
2. A total of 24 stakeholder interviews were conducted with a range of policy makers, program implementation staff, development partners and service providers. (refer Annexure 3 for details)
3. Field visits were made to Hardoi and Sitapur districts. Group discussions and in depth interviews with ASHAs were held in both districts.
4. A core group with representation from the NRHM Directorate, SIHFW, UPSACS, UNICEF, PATH, JHSPH and Mahila Samkhaya was established to provide strategic inputs to the document and to review it (refer Annexure 3 for list of core group members). The core group met four times during the preparation of the document. The draft strategy document was circulated two times during the course of the development process for review by the members of the core group.
5. Regular, on-going reviews, discussions and inputs were provided by the Mission Director, NRHM.

## Structure of the BCC Strategy Document

The strategy document has been divided into two parts. The first part proposes the overall NRHM BCC strategy and the second part works out the operational issues related to implementing the strategy state wide. There is an urgent need for operationalizing the BCC Strategy. Therefore an operational plan is included in the strategy document.

### Part I: The NRHM BCC Strategy

### Part II: Operational Aspects of the BCC Strategy

Developing a BCC strategy for all NRHM programs is a challenge. This document outlines several strategic BCC inputs:

1. A detailed BCC plan on maternal and new born health, child health and family planning.
2. A broad BCC plan for all national health programs (refer modified BCC log frames and Gantt charts).
3. BCC guidelines are provided for campaigns, group meetings and home visits can also be applied to all national programs.
4. A special campaign on prevention and management of outbreaks that involves a strong community involvement component.



## Situational Analysis

The Millennium Development Goals (MDG) provides a set of common targets to countries across the globe to achieve substantial and sustainable improvements in health. India's ability to achieve MDG 4 (reduction in child mortality) and MDG 5 (reduction in maternal mortality) will in large measure depend on the child mortality and maternal mortality indicators of its most populous state, Uttar Pradesh.

### Fertility & Family Planning

Uttar Pradesh has the second highest TFR in India after Bihar (NFHS 3). UP's total fertility rate is 3.8 compared to India's 2.7 (Table 2.1). While the use of temporary contraceptive methods are uniformly low in India and Uttar Pradesh, there is a considerable lag in UP's coverage in terms of female sterilization (Table 2.2). UP's performance in the context of terminal methods has actually declined in the time period between the NFHS 2 and NFHS 3 surveys.

**Table 2.1: Total Fertility Rate in Uttar Pradesh and India**

Health Status Indicators	UTTAR PRADESH		INDIA
	NFHS 2 (1998-99)	NFHS 3 (2005-2006)	NFHS 3 (2005-2006)
<b>TFR</b>	4.03	3.8	2.7

Fertility is another area that requires urgent action if the health of women and children is to improve. UP's family planning profile indicates an overall low use of modern methods (NFHS 3, Table 2.3). About 61 percent of the women 20-24 yrs in Uttar Pradesh were married prior to 18 years. About 30 percent young married women (15 -19 yrs) have very short birth intervals (7-17 months) compared to 15.1 percent in women 20-29 years. Young married women need special focus (they have shorter birth intervals and are at higher risk of adverse maternal and neonatal health outcomes). The reproductive health needs of married adolescents should be given a priority focus.

**Table 2.2: Family Planning Methods**

Indicators	India NFHS 3 2005-2006 Percent	UP (NFHS 2) 1998-1999 Percent	UP NFHS 3 2005-2006 Percent
Condom Use	5.3	4.0	8.7
IUD Use	1.8	0.9	1.4
Oral Pill Use	3.1	1.2	1.7
Female Sterilization	37.3	17.3	14.1
NSV	1	0.5	0.2
<i>Source: NFHS 3</i>			

The district variations in terms of early marriage use of any family planning methods use of modern family planning methods are presented in Table 2.3. The worst performing districts are concentrated in the central and eastern belts of Uttar Pradesh.

**Table 2.3: Marriage & Contraceptive use in UP at State, Urban Poor, Rural & District Levels**

Indicators	India (NFHS 3) 2005-2006 Percent	UP Urban Slum (NFHS 3) Percent	UP Rural (NFHS 3) Percent	UP RCH DLHS 2002-2004	Number of districts below UP Average	10 Worst Performing Districts in Uttar Pradesh
<b>Women (20-24 yrs) married before 18 yrs</b>	44.5	Data not available	61	41.4	32	Maharajganj, Mirzapur, Sant Ravidas Nagar, Shahjahanpur, Gonda, Gorakhpur, Balrampur, Chitrakoot, Badaun, Bahraich, Sonebhadra, Hardoi
<b>Any FP Method</b>	56.3	58.2	43.6	35.6	35	Balrampur, Hardoi, Azamgarh, Kheri, Maharajganj, Sultanpur, Sitapur, Shahjahanpur, Shravasti, Siddharthnagar
<b>Any Modern Method</b>	48.5	50.5	29.3	26.2	37	Azamgarh, Balrampur, Barabanki, Farukhabad, Fatehpur, Ghazipur, Kaushambi, Kheri, Mainpuri, Siddharth Nagar, Shravasti, Sitapur
<b>Unmet Need for FP</b>	13.2	Data not available	21.9	33.6	33	<b>High Prevalance of Unmet need:</b> Rai Bareilly, Sitapur, Siddharth Nagar, Sultanpur, Azamgarh, Ballia, Balrampur, Barabanki, Hardoi, Kheri, Shahjahanpur

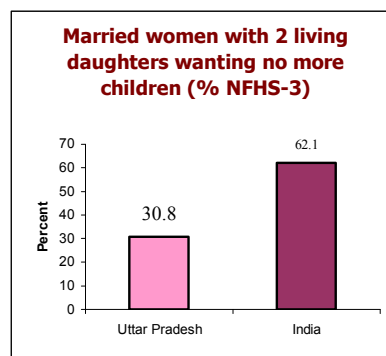
Two areas require further consideration to improve the performance of the family planning programme in UP. First, the issue of unmet need and the need to strengthen the service sector to fulfil these needs and second, the question of son preference and the reluctance to adopt terminal methods until the number of desired sons is fulfilled. Table 2.5 indicates that the unmet need for family planning in UP is much higher (21.9 percent) than the average for India (13.2 percent).

Another underlying reason related to the high TFR in Uttar Pradesh is son preference. Figure 2.1 indicates that only 31 percent of couples in Uttar Pradesh with 2 daughters do not want any more children compared to 62 percent for all of India. Gender discrimination is emerging as an underlying theme affecting infant, child mortality and fertility preferences too.

### Maternal Health

The health scenario in Uttar Pradesh calls for an urgent need for action. UP's maternal mortality ratio (per 1 lakh population) is 517 compared to 301 for India (refer Table 2.4). Developed countries have maternal mortality ratios of about 20 per one-lakh live births<sup>14</sup>. Maternal mortality is largely preventable and with the introduction of the *Janani Suraksha Yojna* (JSY), the priority area for action has already been defined.

**Figure 2.1: Married women with 2 daughters wanting no more children (NFHS-3) (all U.P figures)**

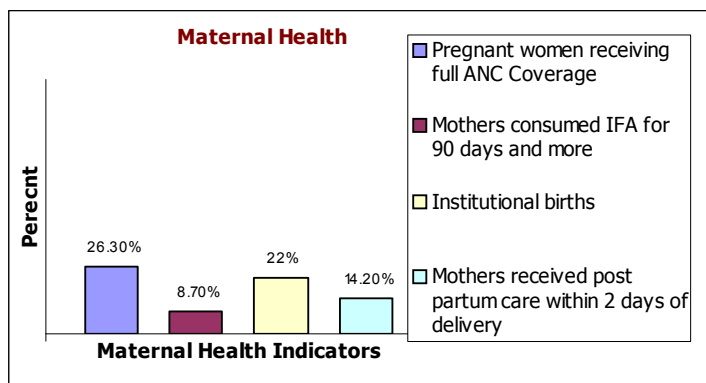


**Table 2.4: Maternal Mortality Ratio in Uttar Pradesh and India**

Health Status Indicators	UTTAR PRADESH		INDIA
	NFHS 2	NFHS 3	NFHS 3
MMR	---	517 per 1 lakh live births*	301 per 1 lakh live births*

Source: \* SRS 2003

**Figure 2.2: Maternal Health Indicators in Uttar Pradesh (NFHS 3) (all U.P figures)**



The overall maternal health coverage indicators are very low in Uttar Pradesh. About 26 percent women reported receiving full antenatal services according to the most recent NFHS survey compared with 52 percent for India. Only 8.7 percent reported completing a full dose of iron and folic acid tablets; institutional deliveries were 22 percent and only 14 percent received a visit from a health care worker within 48 hours of delivery (Figure 2.2).

Table 2.5 provides maternal health coverage for the state in terms of the urban poor, rural areas and district variations. The worst performing districts for maternal health are from the eastern, central and Bundelkhand regions.

<sup>14</sup> WHO, UNICEF, UNFPA. (2003) "Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA." WHO, Geneva.

**Table 2.5 Maternal Health Indicators in Uttar Pradesh**

Indicators	India (NFHS 3) 2005-2006 Percent	UP Urban Slum (NFHS 3) Percent	UP Rural (NFHS 3) Percent	UP RCH DLHS 2002-2004	Number of districts below UP Average	10 -12 Worst Performing Districts
<b>3 ANC Visits</b>	<b>50.7</b>	<b>Data not available</b>	<b>22.6</b>	<b>24.6</b>	<b>39</b>	Balrampur, Chitrakoot, Hamirpur, Kaushambi, Sant Ravidas Nagar, Mahoba, Shajahanpur, Shravasti, Siddharthnagar, Unnao
<b>100 IFA Consumption</b>	<b>22.3</b>	<b>22.9</b>	<b>6.7</b>	<b>Data not available</b>	<b>Data not available</b>	<b>Data not available</b>
<b>Received No TT Injections</b>	<b>19.2</b>	<b>Data not available</b>	<b>30.2</b>	<b>Data not available</b>	<b>Data not available</b>	Kaushambi, Aligarh, Allahabad, Banda, Badaun, Etah, Kheri, Sitapur, Mirzapur, Moradabad
<b>Institutional Delivery</b>	<b>40.7</b>	<b>13.1</b>	<b>17.5</b>	<b>22.4</b>	<b>35</b>	Auraiya, Bahraich, Balrampur, Banda, Bareilly, Hardoi, Kannauj, Pilibhit, Shajahanpur, Shravasti, Unnao
<b>Post natal visit by health provider</b>	<b>14.2</b>	<b>Data not available</b>	<b>9.9</b>	<b>Data not available</b>	<b>Data not available</b>	<b>Data not available</b>

#### Newborn & Infant Health

Uttar Pradesh's infant and child mortality rates are highest in India. Its IMR is 73 per 1000 live births compared to 57 per 1000 live births for India. Similarly, its under-five years child mortality rate is 96 per 1000 live births is highest in India (NFHS-3). There is a wide district level variation in terms of the infant mortality rate. Only 15 districts out of 70 have an IMR of less than 70 per 1000 live births (refer Annexure 4 for district level IMR) and about ten districts have an IMR of > 95 per 1000 live births (refer Table 2.6).

**Table 2.6: Neonatal & Infant Mortality Rates in Uttar Pradesh and India**

Mortality Rates	UTTAR PRADESH		INDIA
	NFHS 2 1998-99	NFHS 3 2005-2006	NFHS 3 2005-2006
<b>NNMR</b>	N/A	48 per 1000 Live Births	39 per 1000 Live Births
<b>IMR</b>	89 per 1000 Live Births	73 per 1000 Live Births	57 per 1000 Live Births

**Table 2.7: Infant Mortality Rates in Uttar Pradesh:**

India (NFHS-3)	Uttar Pradesh (NFHS-3)	10 Districts with high levels of infant mortality in Uttar Pradesh (IMR > 95 per 1000 live births) Census 2001 data
<b>57 per 1000 LB</b>	<b>73 per 1000 LB</b>	Sitapur ( <b>97</b> ), Bahraich ( <b>99</b> ), Maharajganj ( <b>99</b> ), Allahabad ( <b>100</b> ), Shahjahanpur ( <b>100</b> ), Lalitpur ( <b>99</b> ), Etah ( <b>104</b> ), Hardoi ( <b>106</b> ), Balrampur ( <b>107</b> ), Badaun ( <b>110</b> )
<i>Source: S.Irudaya Rajan et al, "Infant and Child Mortality in India: District Level Estimates" New Delhi, Population Foundation of India, 2008</i>		

A further analysis of the IMR data indicates that there are wide gender differentials between girls and boys. The female disadvantage sets in during the post neonatal period (in the neonatal period, the mortality differentials between girls and boys are not there). UP's NNM (neonatal mortality rate) per 1000 live births is 56.2 for boys and 53.2 for girls. However the post neonatal mortality rate is 24.7 for boys and 32 for girls. The child mortality rate (13-60 months) is 21.7 for boys and 43.2 for girls. These differentials are reflected in the overall under-five mortality rate, which is 100.9 for boys, and 124.7 for girls (NFHS-3). The data indicates that efforts to reduce post neonatal mortality and child mortality need to address the issue of female disadvantage in Uttar Pradesh. These differentials vary at the district levels too and Table 2.8 shows that there are 21 districts where female infant mortality is higher by male infant mortality by 6-10 deaths per 1000 live births and 20 districts where the female infant mortality is higher than 10 deaths per 1000 live births. A list of 10 districts in UP with the worst female disadvantage in the context of IMR is also provided in Table 2.8.

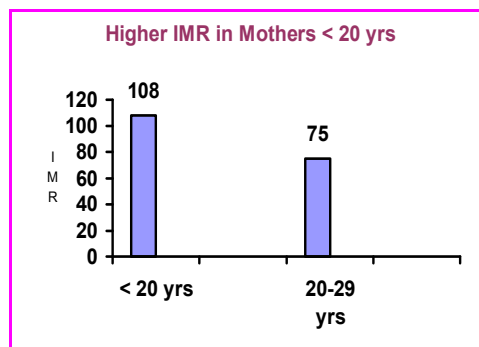
**Table 2.8: District Level Gender Differentials of IMR in Rural Uttar Pradesh.**

Gender Differentials in IMR	No. Of Districts	Percent Districts	10 Districts with Highest Levels of Female Infant Deaths
<b>Low (0-5 points)</b> Female IMR > Male IMR	<b>29</b>	<b>41.4</b>	Gautam Buddha Nagar ( <b>14</b> ), Balrampur ( <b>16</b> ), Ghaziabad ( <b>17</b> ), Hathras ( <b>17</b> ), Firozabad ( <b>17</b> ), Sharawasti ( <b>17</b> ), Sultanpur ( <b>18</b> ), Varanasi ( <b>19</b> ), Mirzapur ( <b>19</b> ), Gonda ( <b>25</b> )
<b>Medium (6-10 points)</b> Female IMR > Male IMR	<b>21</b>	<b>30</b>	
<b>High (10+ points)</b> Female IMR > Male IMR	<b>20</b>	<b>28.6</b>	
<b>Total</b>	<b>70</b>	<b>100</b>	
Source: S.Irudaya Rajan et al, "Infant and Child Mortality in India: District Level Estimates" New Delhi, Population Foundation of India, 2008.			

A greater understanding of the excessive female mortality in the post neonatal period is required. A study found that families with an older girl child had higher levels of female mortality in the 1-12 month period<sup>15</sup>. This implies that infant girl children that already have a surviving older sister are at higher risk of mortality in the 1-12 month period.

Another area of consideration in the context of reducing maternal and infant mortality is the issue of adolescent mothers. IMR is much higher in mothers < 20 years compared to women 20-29 years (Figure 2.3).

**Figure 2.3 Higher Infant Mortality Rate in Mothers (< 20yrs) Compared to Mothers 20-29 yrs in Uttar Pradesh (NFHS-3) (all U.P figures)**



<sup>15</sup> Pebley, A. R. and Amin, S. (1991) "The Impact of a public health intervention on sex differentials in childhood mortality in rural Punjab, India". Health transitions Review, Vol 1, No 2, pp 143-167

However, as far as the issue of female foeticide is concerned, it is the relatively well-developed western region of the state that has the most adverse child sex ratios.

### Newborn Care Practices

A study that looked at newborn care practices in rural mothers in Uttar Pradesh found that the level of appropriate practices was low (Table 2.9). This indicates a need and potential for improvement. Also improving these basic new born care practices would be an essential first step towards saving new born lives.

**Table 2.9: Selected Newborn Care Practices in Rural Uttar Pradesh , n=13,197**

New Born Care Practices	Number	%
1.Cord care	4,278	32.4
2.Both clean instrument and clean thread used ("Clean cord")		
3.Thermal care	1,857	14.1
4.Newborn was both dried and wrapped before the placenta was delivered		
5.Timing of newborn's first bath	2,633	19.9
6.Newborn dried and wrapped immediately or first bath dried after at least 2 days ("Thermal care")		
7.Breastfeeding	656	5.0
8.Within six hours of delivery (Early breastfeeding)		

*Source: Baqui A.H, Williams E.K, et al.: Newborn care in rural Uttar Pradesh. Indian Journal of Pediatrics 2007; 74(3) pp 243*

### Child Health

The child health scenario in Uttar Pradesh does not present a healthy picture (Figure 2.4). Only about 7 percent newborns are breastfed within an hour, 23 percent children (12-23 months) are fully immunized, 85 percent children under three years are anaemic and a mere 7 percent have received Vitamin A. Also, almost half of the state's children under three years are underweight. The indicators of child health that have better coverage are - exclusive breastfeeding for six months (51 percent) and introducing complementary feed at six months (46 percent).

**Figure 2.4: Child Health Indicators in Uttar Pradesh (NFHS-3) (all U.P figures)**

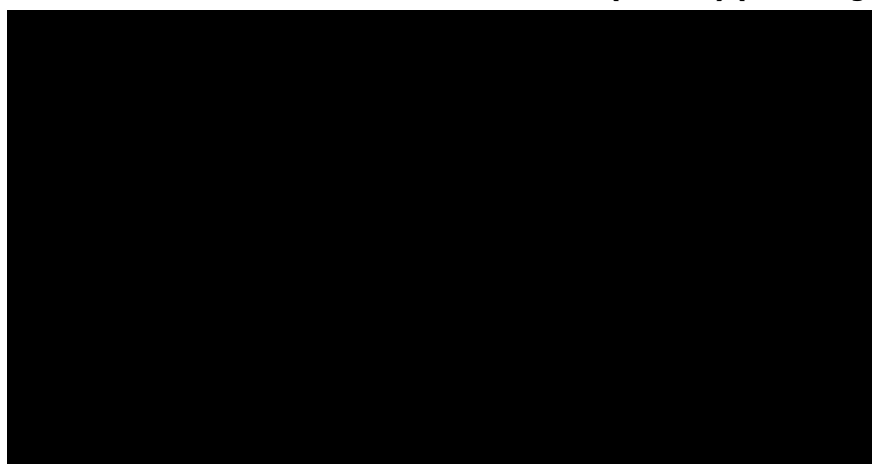




Table 2.10 presents UP data on child health for the urban poor, rural areas, district averages and the 10 worst performing districts in Uttar Pradesh. Breastfeeding within the first hour is only 5.5 percent for the urban poor and 6.9 percent in rural areas. Also almost 45 districts are below the UP average for this already low performing indicator. The practice of giving the newborn prelacteal feeds is very high in Uttar Pradesh. Both the urban poor and rural samples reported an 87 percent level of prelacteal feeding practices for the newborn. ORS coverage is also low as is complete immunization. Treatment seeking for ARI and fever symptoms is quite high.

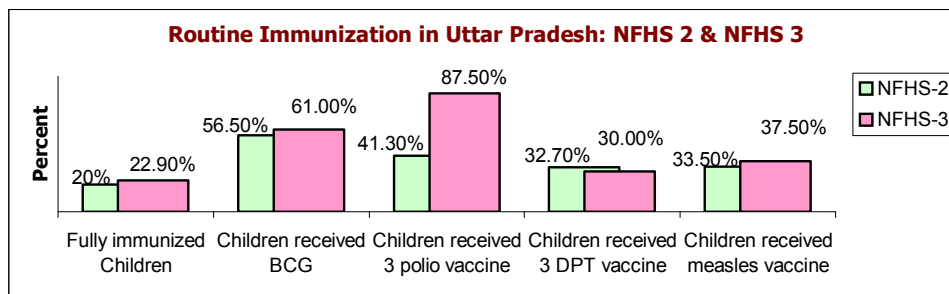
**Table 2.10: Child Health**

Indicators	India (NFHS 3) 2005-2006 Percent	UP Urban Slum (NFHS 3) Percent	UP Rural (NFHS 3) Percent	UP RCH DLHS 2002-2004	Number of districts below UP Average	10 Worst Performing Districts
<b>Breast feeding within 1 hour</b>	<b>24.5</b>	<b>5.5</b>	<b>6.9</b>	<b>7.9 Within 2 hrs</b>	<b>45</b>	Kaushambhi, Sant Ravi Das Nagar, Badaun, Etah, Firozabad, Allahabad, Shrawasti, Unnao, Ambedkar Ngr, Fatehpur
<b>Prelacteal feed during first 3 days</b>	<b>57.2</b>	<b>87.8</b>	<b>87</b>	<b>Data not available</b>	<b>Data not available</b>	<b>Data not available</b>
<b>&lt; 5 yrs had diarrhoea</b>	<b>9.0</b>	<b>13.6</b>	<b>8.1</b>	<b>19.7</b>	<b>34</b>	Farukkabad, Etah, Badaun , Kushinagar, Kannauj, Bareilly, Rampur, Kanpur D, Gonda, Barabanki
<b>Any ORT or increased fluids</b>	<b>43.0</b>	<b>29.9</b>	<b>25.4</b>	<b>15.5</b>	<b>33</b>	Farrukabad, Gorakhpur, Ferozabad, Gonda, Jyotibaphule Nagar, Mainpuri, Pratapgarh, Mathura, Saharanpur, Sant Ravidas Nagar, Shrawasti
<b>ARI + Fever</b>	<b>5.8</b>	<b>11.0</b>	<b>7.1</b>	<b>14.0 had pneumonia</b>	<b>30</b>	Ghaziabad, Bulandshar, Bharaich, Mathura, Aligarh, Shrawasti, Saharanpur, Rampur, Hathras, Etawah
<b>Sought treatment for ARI / Pneumonia</b>	<b>69</b>	<b>82.3</b>	<b>70.4</b>	<b>79.2</b>	<b>27</b>	J.P. Nagar, Ferozabad, Ambedkar Nagar, Fatehpur, Jalaun, Kanpur N, Sant Ravidas Nagar, Mirzapur, Sultanpur, Gonda
<b>Full Immunization</b>	<b>43.5</b>	<b>35.1</b>	<b>20.5</b>	<b>28.1</b>	<b>40</b>	Kaushambi, Badaun, Sitapur, Moradabad, Mathura, Balrampur, Jalaun, Etah, Mahoba, Shrawasti

There has been an influx of funds to India for polio eradication. Sadly, this focus has not translated into improved overall immunization coverage for children. In fact the routine immunization programme shows no improvement except in the case of polio from the NFHS 2 to NFHS 3 time periods. Figure 2.5 indicates insignificant increases in routine immunization coverage in Uttar Pradesh except for polio.

The proportion of children who are fully immunized has barely increased between the two surveys. Measles coverage continues to be low.

**Figure 2.5 Routine Immunization**



### Maternal, Adolescent and Child Nutrition

A BCC strategy has to consider crucial areas of prevention that can provide sustained improvements in health. One such area is nutrition. India has high levels of under nutrition in children, adolescent girls and women. Improving nutritional status of these populations in Uttar Pradesh is feasible through focussed BCC<sup>16</sup>.

A Planning Department Report (Government of UP)<sup>17</sup> states the following,

1. UP ranks second in terms of malnutrition levels of children under three
2. Every second adolescent girl is anaemic
3. Fifty seven percent children born to undernourished mothers are underweight
4. Every sixth malnourished child in India lives in UP
5. About 49 percent women weigh less than 45 kgs

Anaemia sets in early in life - about 85.1 percent children (6-59 months) are anaemic. Only 6.9 percent of these children had consumed an iron rich food in the last 24 hours (NFHS-3). Iron deficiency anaemia continues through the life cycle of girls into their adolescence and adulthood. About 50.9 percent married women are anaemic (NFHS-3). The government's IFA tablet programme for pregnant women more than 40 years old. However, iron deficiency anaemia remains high in pregnant women too.

### Tuberculosis

The prevalence of TB in UP is not very different from the all India prevalence (Table 2.11). The NFHS data shows a high association between type of cooking fuel and the prevalence of TB. Cooking fuels such as coal, ignite, charcoal, dung cakes etc. is associated with higher TB prevalence.

**Table 2.11: TB Prevalence in Uttar Pradesh and India**

Health Status Indicators	UTTAR PRADESH	INDIA
<b>TB Prevalence</b>	450 per 1 Lac	445 per 1 Lac
<i>Source: NFHS 3</i>		

<sup>16</sup> Kapadia-Kundu, N. and Tupe, R. (Forthcoming). IHMP demonstrated a decline in grade II malnutrition in children under-three years from 36 percent to 8 percent in urban slums in Pune, Maharashtra. Similarly, a cluster randomized trial indicated an improvement in the BMI (body mass index) of unmarried adolescents through focussed nutrition education. Both interventions included BCC at the household and community levels.

<sup>17</sup> Planning Department, UP Government (2005) "A Note on the Health Sector". pp 17

---

## Lack of BCC Capacity in Uttar Pradesh

A critical component for the development and implementation of planned BCC inputs at a State level include the availability of human resources with the capability of implementing BCC programs as behaviour change programs. The stakeholder interviews indicated that many health personnel including those at the IEC Bureau have a limited understanding and orientation to BCC. A policy maker defined BCC as provision of “awareness to the masses”. A simplistic definition of BCC exists at all levels. It assumes that “people are ignorant and therefore need information”. This myopic view of the behaviour change process does not take into account the determinants (barriers and enabling factors) of behaviour change. It is necessary to focus on the causes of the barriers and learn from the enabling factors to promote strategies of behaviour change. For example, it is essential to plan BCC inputs on how to organize emergency transport for pregnant women instead of merely telling women to go to a health facility.

A UNICEF assessment on “Enhanced Capacity of Government Partners for BCC” (May 2007) came to the same conclusion. It states, in the context of UP, “in-depth clarity on BCC, its distinction from traditional IEC and the right approach to BCC is not evident in the planning, implementation and monitoring of BCC” (pp 114). The need to build BCC planning capacity exists, not only in Uttar Pradesh, but in other parts of the country too. A structured training needs assessment of District Media Extension Officers in Maharashtra assessed BCC conceptual skills on the following four parameters: linking behavioural change as an outcome of BCC/IEC efforts, understanding the concept of behavioural analysis, principles of persuasion and how adults learn. It was found that the conceptual skills of district media and extension officers were weak on all four parameters. The district media officers also stated that they were used primarily to “operate electronic equipment” rather than as strategic planners and managers of BCC programs<sup>18</sup>.

## ASHA’s BCC workload not clearly outlined

Situational analysis and group discussions with ASHAs revealed that there is no uniform BCC strategy in place in terms of group meetings and home visits to be undertaken by ASHAs. Some said they went to their field area twice a week, others said twice a week and yet others said 4 times a week. Also, many ASHAs are conducting group meetings. However in absence of any guidelines, each of the ASHAs selects the topic of the group meeting randomly and often uses the entire flipbook during the meeting covering all the NRHM issues during one sitting. (Provided by the Health Dept)

### BCC Gaps

The stakeholder interviews highlighted the following gaps:

1. Weak BCC supervision at the state, district, block & village levels
2. Weak capacity for planning and Implementing BCC programs
3. Weak community based BCC inputs
4. Uncoordinated and unfocussed mass media campaigns
5. Lack of adequate BCC capacity in the state to implement BCC programs at scale
6. Need for orientation of all health personnel in the state on “What is BCC?”

---

<sup>18</sup> IHMP (1996) “District Extension Media Officers Training Needs Assessment”.

---

## Summary

The situational analysis indicates the following health scenario in Uttar Pradesh:

- Uttar Pradesh has the highest infant and child mortality rates in India.
- Infant mortality rates are higher in young mothers (< 20 years) compared to women 20-29yrs.
- UP's maternal mortality ratio is also very high, second only to Bihar
- There are stark gender differentials in the post neonatal mortality and child mortality rates indicating gender bias against the girl child.
- Maternal coverage in terms of antenatal care, institutional deliveries and postnatal care is low.
- There have been minimal gains in routine immunization coverage between NFHS2 (1999-1998) and NFHS3 (2005-2006) surveys with the exception of polio.
- Uttar Pradesh's contraceptive profile indicates that while contraceptive prevalence is 43 percent, the use of modern contraceptives remains relatively low (29.3 percent).
- There is very little increase in the use of spacing methods between the NFHS 2 and NFHS 3 surveys. Also, a much higher proportion of married adolescents (15-19 yrs) have birth intervals less than 18 months compared to women 20-29yrs.
- The use of terminal methods is driven by son preference with only 30 percent of women in Uttar Pradesh with two daughters not wanting another child compared to 62 percent for India.
- A very large unmet demand for contraceptive methods exists in Uttar Pradesh, indicating that services are not reaching those who need them.
- New born care practices are another area where there is scope for improvement
- Anaemia levels in women and in children ages 6- 36 months are very high.
- In terms of child health, improvement in hygiene practices will help in the reduction of diarrhoeal diseases.
- TB rates in Uttar Pradesh are almost equal to the India average. The RNTPC programme covers the entire state. TB was mentioned as one of the most effectively run national programme in Uttar Pradesh by many of the stakeholders interviewed.
- The capacity to implement strategically planned and monitored BCC programs will have to be built in Uttar Pradesh.

## NRHM Behavior Change Communication Strategy

### Selection of Priority Behaviors & BCC Barriers Analysis

There are about 10 National Health Programs under the NRHM umbrella ranging from maternal health to blindness control. This BCC strategy proposes a two-pronged approach to circumvent the dilemma of addressing too many care seeking and household behaviours at one time. The approach includes:

- The selection of priority behaviours for mass promotion and
- Addressing specific behaviours through interpersonal communication (IPC) and community based BCC approaches.

The purpose of identifying priority behaviours is to assist in developing a focussed BCC strategy over three years that can contribute to sustainable change in the health of communities in Uttar Pradesh. Specific behaviours related to each National Health Programme will be addressed at the facility, household and community level using IPC tools that enable need specific BCC. Need based BCC at the household level, represents a considerable shift away from “prescriptive one-way messages”. Need based BCC focuses on establishing dialogue and motivating change that can be easily assimilated within the socio-cultural milieu of communities in Uttar Pradesh.

The priority areas for BCC focus within NRHM based on the situational analysis of Uttar Pradesh are:

#### Priority Areas for BCC Strategy

1. Antenatal Care
2. Institutional Deliveries
3. Post Natal & New Born Care
4. Married Adolescents
5. Gender discrimination (female foeticide, infant girl, under 5 girl, son preference and therefore large family size)
6. Unmet need for family planning
7. Nutrition through the life cycle (infant, under three, adolescent, woman)
8. Routine immunization
9. Hygiene and safe water practices
10. Marginalized groups and households including urban poor
11. Need for supportive supervision of ASHAs
12. Capacity building of BCC skills for service providers across NRHM
13. Workload definition and structuring of workload for the ASHAs

---

### BCC Barriers Analysis:

The behavioural analysis for NRHM has indicated that several common themes are emerging related to behavioural barriers. One of these themes is working with families and communities to overcome barriers at the household level. Behaviours in the household and/or community realm are not dependent on health services. These include hygiene, nutrition, newborn care related behaviours. In addition, community level behaviours include prevention of mosquito breeding sites etc.

Barriers related to health providers and health services are another common theme. These barriers range from lack of regular outreach and other health services to low motivational levels and low community accountability of the service provider. Changing attitudes of public sector providers is an important issue.

Gender discrimination at most stages of the life cycle is another all-pervasive barrier in the context of health. The situational analysis indicates that in UP, the unborn girl child, female infants, girls who are under-three years are at a higher risk of mortality than boys because of their gender. Apart from gender differentials in mortality, female disadvantage is seen in high levels of anaemia in adolescent girls and women, maternal mortality and morbidity. Strong son preference influences family size and the use of terminal family planning methods.

The lack of transport services from the village level to the secondary and tertiary levels of care comprise another set of barriers. Often transport is not available to the nearest FRU (First Referral Unit) especially at night. These barriers prevent families from accessing emergency health care that can save lives of women and children.

The lack of adequate supervisory and monitoring capacity for implementing BCC programs at scale is another barrier. This includes building capacity at all levels of providers towards defining BCC as a process of changing behaviours (Table 3.3).

The proposed BCC strategy focuses primarily on the above-mentioned themes, that are based on the barriers and the modified log frame analysis presented in Chapter 3. The overarching BCC strategy for UP outlines a set of priority behaviours that will enable the development of focussed interventions.

A detailed evidence based barriers analysis for all the national health programs is presented in Annexure 6. The logical framework analysis format is routinely used for planning health programs but it has rarely been used for planning BCC interventions<sup>19</sup>. A modified logical framework analysis (LFA) has been used in this strategy document. A barriers column has been added to the LFA format because it is necessary to derive BCC interventions and strategies based on evidence based barriers. Otherwise, there is a risk of falling into the “knowledge-behaviour gap” where BCC strategies focus primarily on awareness creation.

The barriers to behaviours, interventions to address the barriers, strategy, workload and monitoring indicators are presented for each of the priority behaviours in a modified log frame format. The first step has been to identify the socio-cultural, health service, socio-economic and environmental barriers associated with the priority behaviours. The detailed modified BCC LFAs for each national programme are in Annexure 6.

Evidence is provided to support the contextual barriers listed in the modified log frame analysis. The barriers try to go beyond the simplistic “lack of information/ lack of knowledge” rationale that is often put forward as the main obstacle to behaviour change. Instead the attempt is to understand

---

<sup>19</sup> The Institute of Health Management Pachod (IHMP) has trained many NGOs and government personnel in the development of LFAs. A large part of the BCC LFAs prepared for this strategy document draws from this experience.



---

the social and communication contexts that are rooted in the culture of the communities that are being addressed by the BCC programme. The strategy relies on formative and anthropological research conducted in Uttar Pradesh and elsewhere in India to assess the contextual barriers to the priority behaviours. It also draws upon formative research conducted for RCH by the Institute of Health Management Pachod to develop a district BCC plan for Maharashtra<sup>20</sup>.

The modified LFA format provides an overall objective (reduction in mortality; reduction in TB or vector borne diseases etc.) and then the behavioural objectives are stated. This is followed by a barriers analysis or reasons why certain behaviours are not occurring (column 1). The barriers are listed under the following categories - socio-cultural, health service, socio-economic, lack of infrastructure (such as transport) etc. Identification and selection of barriers is largely evidence based with references listed at the end of the modified log frame. However good formative research providing contextual barriers has been scarce and in some instances stake holder interviews have been the source of identification of a barrier. The core purpose of the modified log frame is to design BCC interventions to address the barriers (column 2). The interventions are then followed by columns on strategies and activities (columns 3 and 4). Strategies include different types of BCC methods - home visits, mass media, group meetings etc. Activities required to implement the strategies are then listed in the next column (column 4). These are listed in brief due to lack of space. The workload to undertake the activities is briefly stated (column 5). The monitoring indicators for each intervention are also listed (column 6).

BCC LFAs have been prepared for the following programs:

1. Maternal and Newborn Health
2. Institutional Delivery and Hospital Stay of 24 hours
3. Newborn Care
4. Family Planning
5. Nutrition of Adolescents and Women (adolescent girls, married women, pregnant women)
6. Child Health
7. Routine Immunization
8. RNTCP (Revised National Tuberculosis Control Programme)
9. Vector Borne Diseases
10. National Programme for Control of Blindness

**A brief summary of each BCC LFA is presented below (please refer Annexure 6 for details and evidence base BCC barriers)**

### **1. Maternal and Newborn Health**

The main socio-cultural barriers to early registration (< 12 weeks) and 3 antenatal check ups are: no perceived need for ANC check ups as previous deliveries were normal despite no ANC check ups; lack of social norm of early registration and low autonomy and status of women in Uttar Pradesh. The health service barriers are - no trust in government system; infrequent visits by ANM to village, transportation and medicine costs etc<sup>21</sup>. Other barriers include lack of access to resources including ANC related information.

---

<sup>20</sup> IHMP, (1998) "Social Assessment: Reports 1 & 2". (unpublished)

<sup>21</sup> The references related to the barriers to maternal and newborn health are:

V. Sethi et al. (2005) "Contextual Factors Influencing Newborn Care amongst the Rural Poor in Western Uttar Pradesh" Pakistan Journal of Nutrition 4 (4) 273-275

---

The behavioural inputs are aimed at: (1) Motivating women and families to avail of ANC services, (2) Motivating ANMs and MPWs to provide quality and timely services at the community level and (3) Motivating community members and the village health and sanitation committees to organize emergency transport and ensuring services reach the poorest households; and motivating community members to demand services as per government norms.

## **2. Institutional Delivery and Hospital Stay of 24 hours**

There are two critical aspects being addressed in this modified BCC log frame - the issue of institutional delivery and equally important, the need to be in a facility for 24 hours prior to discharge. The barriers to institutional delivery are “age old practice of home deliveries”, lack of services nearby or at a village level, lack of transport etc. Interviews at the PHC level and with ASHAs indicated that the woman’s family often takes discharge from the facility after the baby is born and does not wait for 24 hours at the PHC.

The behavioural inputs required are: (1) Motivating women, families and communities to avail of *Janani Suraksha Yojna*, (2) Promoting registration at a facility for delivery as part of a birth preparedness plan, (3) Motivating community members and village health and sanitation committees to organize emergency transport for institutional deliveries and making transport arrangements if labour occurs at night (4) Motivating Medical Officers and PHC staff to keep mothers and new borns at the facility for 24 hours.

## **3. Newborn Care**

The barriers analysis related to newborn care practices indicate there are long standing socio-cultural practices related to prelacteal feeds, discarding colostrum, cleaning the baby’s digestive system etc<sup>22</sup>. There is also fear that the baby could be harmed if certain practices are not followed. Weighing the newborn within 24 hours is a practice that can find quick acceptance if promoted in a culturally appropriate and locally acceptable manner.

The behavioural inputs required to change new born care practices include: (1) Motivating pregnant women and older female family members to put the child to the breast within one hour of delivery; (2) motivating dais and ANMs to put the baby to its mother’s breast within one hour of delivery; (3) motivate mothers and other family members for providing skin-to-skin care to the new born; (4) motivate family members to ensure that the child is weighed within 24 hours of birth; even if the child is born at home; (4) Promote new born care to caretakers of the mother and newborn as a “care” package that is feasible and easy to implement at a household level.

## **4. Family Planning**

The main barriers to low use of family planning methods are - social norm of proving fertility within one year of marriage, son preference, lack of quality of care, limited outreach of FP services in terms of frequency and regularity. Mothers-in-law stated they preferred doctors as providers of IUDs. Also couple communication and family discussion on contraceptive use is low<sup>23</sup>.

---

K. Gupta and Yesudian, P. P. (2006) “Evidence of Women’s Empowerment in India: A study of Socio-Spatial Disparities” *Journal of Geo-Social Studies* 65: pp 365-380

“Home and community based interventions involving health extension or community health workers have a substantial impact on neonatal mortality including mortality in the first week of life”. Expert Consultation on Community Based Approaches for Neonatal Sepsis Management, London, Sept 26-28, 2007. pp 29

N. Chaudhary, J. Hammer et al (2006) “Missing in Action: Teacher and Health Worker Absence in Developing Countries” *Journal of Economic Perspectives*, Vol 20, No 1, Winter, pp 91-116

<sup>22</sup> Kumar, V. Mohanty, S. et al 2008 (submitted) “Impact of Community based Behaviour Management on Neonatal Mortality: a cluster, randomized control trial in Shivgarh, Uttar Pradesh”

Reissland, N. and Burghart, R. (1988) “The Quality of a Mother’s Milk and the Health of her Child: Beliefs and Practices of the Women in Mithila”. *Social Science and Medicine*, vol 27, No 5, pp 461-469

<sup>23</sup> Koenig, M., Foo, G., Joshi K. (2000)

---

The behavioural inputs required are: (1) Directly address newly married couples and motivate them to delay first conception; (2) Promote spacing between 2 children by motivating men; (3) Motivate health care workers to provide regular and good quality family planning services; (4) Promote use of terminal methods after 2 children; (5) Promote couple communication and family discussion on temporary and terminal methods.

#### **5. Nutrition of Adolescent & Women (adolescent girls, married & pregnant women)**

The main barriers here are that some households do not have food security and the general norm of eating twice a day only. Addressing under nutrition in girls and women has the potential of having multiple gains in terms of prevention of anaemia, low birth weight babies and maternal mortality.

The behavioural inputs needed are: (1) Promote 3 meals a day (2 meals and a snack) for women and girls in food secure families; (2) Promote 4 meals a day (2 meals and 2 snacks) for pregnant and lactating women in food secure households; (3) Promote consumption of an iron rich food daily in combination with Vitamin C foods for girls and women; (4) Promote linkages with anganwadi for food insecure households; (5) Promote consumption of IFA tablets for pregnant women; (6) Promote DOTS approach for IFA tables for girls 9-14 years.

#### **6. Child Health**

Child health includes the following areas - nutrition of child under three years, prevention and management of diarrhoea and ARI, hygiene and safe drinking water, and immunization (refer modified BCC log frame 8 in Annexure 6).

The behavioural inputs needed for child health are: (1) Promote value of girl child by motivating elders, samiti members, parents based on “spiritual merit” approach; (2) Promote hand washing with soap after defecation in every household; (3) Promote introduction of complementary feeds at six months through regular home visits and focus on frequency of feeds; (4) Promote appropriate management of ARI and diarrhoea through regular home visits; (5) Promote safe drinking water through community level approaches.

#### **7. Routine Immunization**

The routine immunization programme has the following barriers: lack of community ownership, RI sessions are often not held as planned, weak BCC programme, lack of quality services and negative impact of pulse polio campaign.

The behavioural inputs needed are: (1) A campaign strategy that emphasizes 5 contacts with the health system for immunization in the child’s first year of life; (2) motivating health care workers to provide regular immunization sessions at the village level; (3) simplifying the immunization campaign by reducing the focus on “number and types of vaccines” to a colour coded 5 contact system; (4) Motivating parents through community change agents

---

“Quality of Care Within the Indian Family Welfare Programme: A Review of Recent Evidence”. Studies in Family Planning, vol 31, No 1, pp 1-18; Uttar Pradesh had among the lowest outreach coverages by ANM and MPW. Kumar, A. and Das, M. (2008) “Towards Equity in Health: A Study of Barriers in Accessing RCH Services in Uttar Pradesh”, ITAP, Futures Group International  
“Knowledge and Perceptions about Reproductive Health Issues, and Mother-in-Law: Uttar Pradesh”. Constella Futures, July, 2007

---

## 8. RNTPC (Revised National Tuberculosis Control Programme)

The TB programme in Uttar Pradesh is one of the best-implemented national programs in the state. The TB programme has outlined a well-planned BCC strategy in the State PIP. In addition it also has clear implementation and monitoring mechanisms at the district and block levels.

The main barriers to the programme are - lack of detection as per norm; lack of effective collaboration with medical colleges; lack of supervision at district level; lack of knowledge in urban slums and private practitioners not adequately engaged with RNTCP.

The behavioural inputs required are: (1) Prepare behaviour specific BCC materials (2) Prepare a detailed plan for the one-week TB campaign (3) Apply BCC guidelines provided in the strategy document to mass media, wall writings, group meetings, home visits etc.

## 9. Vector Borne Diseases

The main barriers in terms of the vector borne diseases are lack of community involvement, lack of plans on prevention and management of outbreaks and lack of surveillance.

The behavioural inputs required are: (1) Prepare outbreak management campaigns; (2) Build capacity of village health and sanitation committee on outbreak prevention and management (3) Develop outbreak preparedness plans at village, block and district levels.

## 10. National Programme for Control of Blindness

The main barriers to the national programme for control of blindness are - NGO proposals have been pending and BCC efforts have not been systematic.

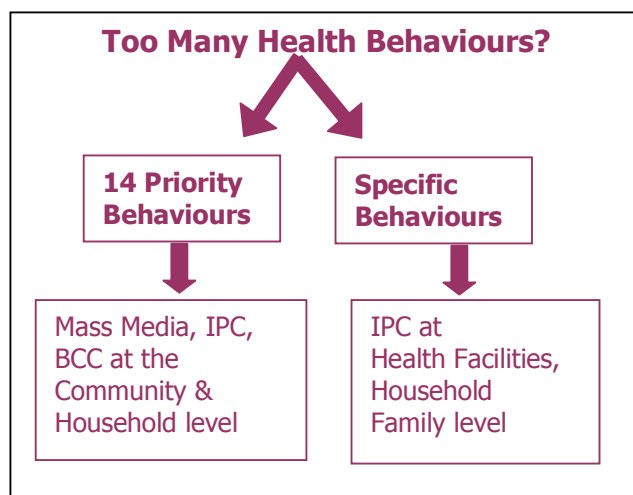
The behavioural inputs needed are: (1) Using guidelines provided in the strategy document to develop BCC materials; (2) Develop behaviour focussed campaigns; (3) Use a school based eye screening programme to include a child-to-family approach for reaching older people.

Annexure 6 provides the BCC log frames. The log frames are the foundation on which the detailed BCC strategy for NRHM is outlined and operationalized in the rest of the chapters. The BCC log frames can be used as a guiding framework for preparing BCC district level and block level action plans for all the national health programs.

### Identification of Priority Behaviours:

Uttar Pradesh's BCC strategy has been developed by identifying priority behaviours within a wider spectrum and cluster of NRHM behaviours.

Figure 3.1: Core Behaviours



Thereafter, the barriers to these priority behaviours have been assessed. The proposed BCC strategy is designed to address the barriers. Priority behaviours across all NRHM programs have been selected based on the following criteria:

1. Evidence of association of the behaviours to prevent outcomes such as maternal mortality, neonatal and child mortality, anaemia, TB, vector borne diseases etc.
2. Expert opinion of the core group committee guiding the development of the NRHM BCC strategy in Uttar Pradesh.
3. Magnitude of the behavioural problem and potential for change through BCC approaches.

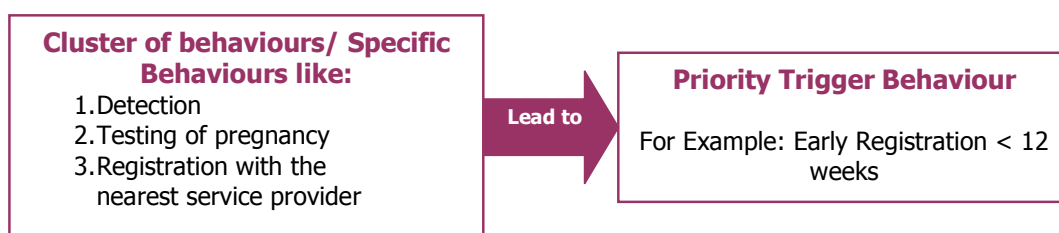
The core group established for providing strategic inputs for the BCC strategy identified a list of 27 important behaviours across 10 national health programs (Annexure 5). 14 priority behaviours for NRHM have been further selected from the list of 27 behaviours.

**Table 3.2 Priority Behaviours for BCC Campaigns**

<b>14 Core Trigger Behaviours</b>	
1.	Age at marriage > 18 yrs; Delay first pregnancy till 21 years for girls
2.	Eat three times a day (women and adolescent girls); eat 3-4 times a day (pregnant women)
3.	Early registration <12 weeks; 3 ANC check ups
4.	Institutional Delivery; Stay in the hospital for 24 hrs after delivery
5.	Immediate health seeking behaviour on recognition of danger signs in mother and newborn
6.	Immediate and exclusive breast feeding within one hour of birth and continue exclusive breast feeding up to six months
7.	Keep the newborn warm with skin to skin care
8.	Complete Immunization/ Booster / Vit A
9.	Complementary feeding from six months 4-5 times a day in addition to breast feeding
10.	Wash hands with soap after defecation and prior to feeding child under three years
11.	Increase birth interval to three years
12.	Adopt any limiting method after two children even if both are girls
13.	Early detection of TB
14.	Empty and dry water containers once a week

A useful categorization for addressing the dilemma of too many health behaviours is that of “priority” behaviours and “specific behaviours”. A priority behaviour is the main outcome or expected behavioural change. However there are a set of ancillary behaviours that enable the “priority behaviour”. For example, early registration (< = 12 weeks) of pregnancy is an outcome behaviour. To facilitate this behaviour, early detection of the pregnancy at the community level is required, followed by confirmation of pregnancy through testing and/or physical examination and then registration with the nearest health provider<sup>24</sup>.

<sup>24</sup>N. Kapadia-Kundu, A. Dyalchand, M. Khale, Institute of Health Management Pachod, 2007. “An Introduction to Behaviour Change Communication”



### Barriers to Behaviour Change: Emerging Themes

Barriers to behaviour change in four broad areas have been identified - socio-cultural, health services, socio-economic and infrastructure and BCC capacity.

**Table 3.3 Barriers to Behaviour Change: Emerging Themes**

<b>1. Socio-Cultural Barriers</b> <ul style="list-style-type: none"> <li>▪ Gender discrimination; son preference</li> <li>▪ Norm of early child bearing/early marriage</li> <li>▪ Colostrum feeding &amp; other new born care practices</li> <li>▪ Dietary pattern of eating two meals a day, women eat last</li> </ul>
<b>2. Health Services</b> <ul style="list-style-type: none"> <li>▪ Lack of regular outreach services at the village level</li> <li>▪ Health provider attitude and low motivation levels</li> <li>▪ Lack of trust in public sector services</li> </ul>
<b>3. Socio-Economic and Infrastructure</b> <ul style="list-style-type: none"> <li>▪ Transport constraints</li> <li>▪ Households with food insecurity</li> </ul>
<b>4. BCC</b> <ul style="list-style-type: none"> <li>▪ Too much focus on awareness creation</li> <li>▪ Limited reach of mass media in rural Uttar Pradesh</li> <li>▪ Weak systems for BCC supervision</li> <li>▪ Community based BCC (IPC, group meetings, community events) is limited</li> <li>▪ Uncoordinated mass media campaigns</li> </ul>

The key barriers within the socio-cultural realm include broad community wide norms related to son preference which translate into discriminatory actions against the girl child to a finite set of new born care practices at the household level (Table 3.3).

Another set of barriers relate to the provision, quality and availability of services. Lack of regular outreach services at the village is a barrier to health service behaviours such as 3 ANC check ups during pregnancy. The lack of trust in public sector health services and low motivation levels of health staff are other barriers.

Socio-economic and infrastructural barriers also impede health and health seeking behaviours. Another set of barriers are related to the conceptual, technical and planning capacities in the state to implement behaviourally focussed, planned BCC programs. Implementation of the BCC strategy will hinge on building this capacity within the state.



## NRHM Behavior Change Communication Strategy

### Overarching Strategy, BCC Interventions & Innovations

The NRHM BCC strategy has implications for the way BCC is going to be conceptualized and implemented in Uttar Pradesh. The full fledged implementation of the BCC strategy will take several years and will require ongoing commitment towards building BCC resources in the state. Unfortunately, BCC is being implemented on an activity-to-activity basis, rarely as a planned programme. Activity based BCC results in resources being poured into short term inputs that have no clear outcomes or gains. In such a scenario, ad hoc, poorly planned BCC interventions take centre stage instead of defined outcomes.

An overarching BCC strategy is proposed for the state. This strategy has been derived from the situational and barriers analysis. The overall strategy hinges on the adherence to behaviour focussed programming. The goal of the overarching strategy is to provide a set of integrated BCC inputs across various levels of intervention (state, facility, community and household) covering a three year time frame. The overarching BCC strategy accords interpersonal and community level efforts equal if not more importance than mass media interventions. The overarching strategy recognizes that coordinated, planned efforts will result in powerful and sustainable changes.

The three overarching strategies are: (1) IPC and community level BCC, (2) Community level mobilization and (3) Mass media. Each of these overarching strategies has been described in detailed operational guidelines. The purpose of presenting the all three broad strategies together is to underscore the need to work with all three approaches instead of the singular focus on mass media. Each of the broad strategies is considerably strengthened if implemented synergistically and simultaneously.

The NRHM BCC strategy broadens the scope of BCC to address the barrier of irregular service provision at the outreach level through provider focussed campaigns; it also aims to use BCC approaches to enable communities to demand health services as per the norms laid down by the Government of India<sup>25</sup>. The overarching BCC strategy can be applied to the entire state and its national health programs. Detailed guidelines and frameworks for operationalizing this strategy at the village, block and district levels are outlined in the BCC strategy document

The proposed BCC strategy includes the use of mass media, community based BCC (IPC, group meetings and local events) and community mobilization in a coordinated manner. The first year will focus on getting the mass media, IPC and community level BCC activities implemented across the state. The long term strategy will focus on developing BCC planning capacity in the state, while continuing with the BCC implementation activities of the integrated campaigns. The long term

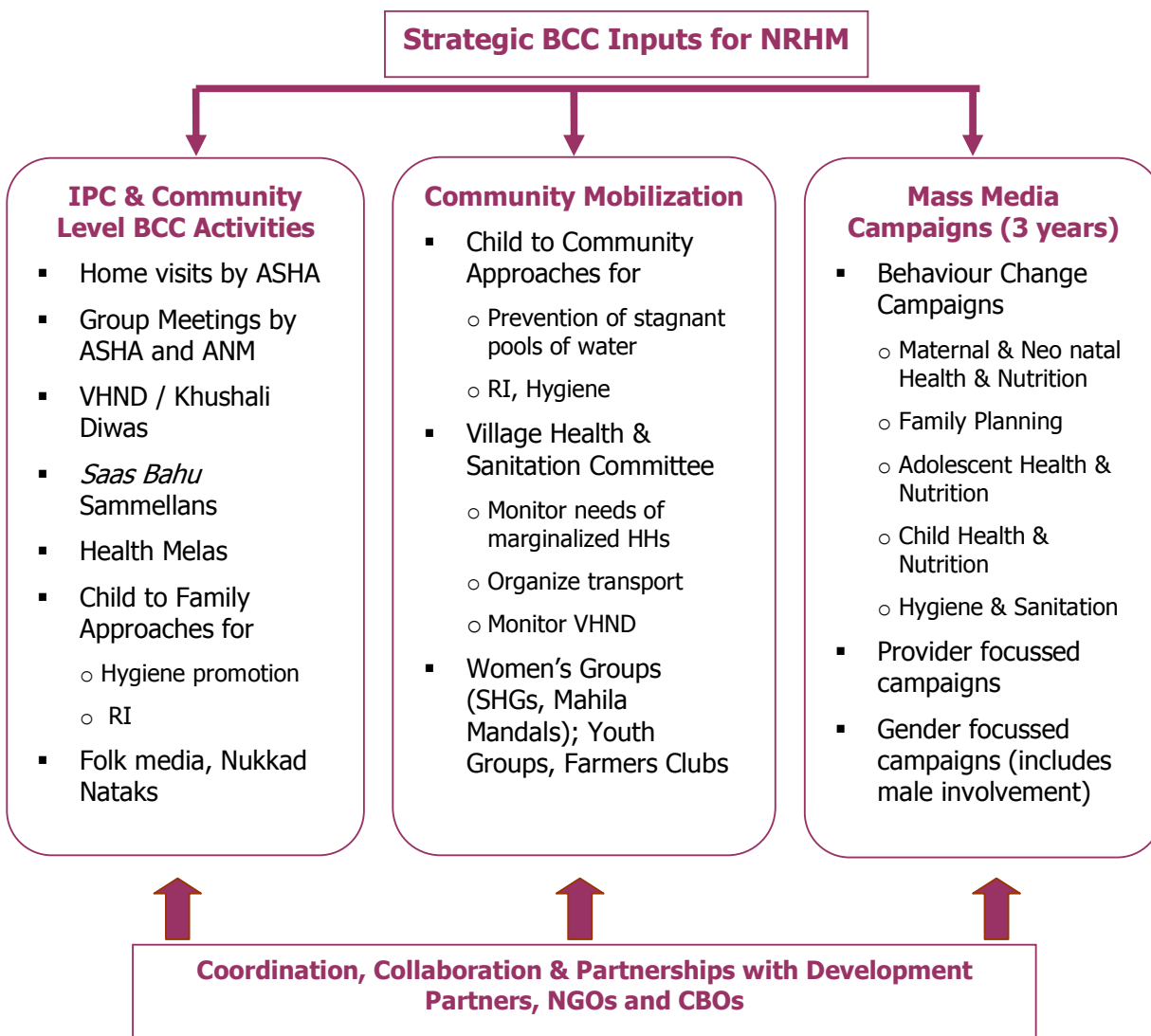
<sup>25</sup> In the context of India, and especially Uttar Pradesh, it is necessary to consider the role of BCC beyond “demand generation”. This because health services are often not available at the community level and when available, they are likely to be of poor quality (Koenig et al, (2000) “Quality of Care Within the Indian Family Welfare Programme: A Review of Recent Evidence” Studies in Family Planning, vol 31 No 1 pp 1-18.

strategy aims to strengthen monitoring and review of BCC implementation in the state. In addition, there will be the introduction of several BCC innovations in the state.

### Overarching BCC Strategy for NRHM in Uttar Pradesh

The core strategic input for the NRHM BCC strategy will centre around interpersonal communication and community level BCC activities. This in turn will be supported by mass media and community mobilization interventions. Figure 4.1 shows that the effective implementation of strategic BCC inputs is dependent on partnerships, coordination and collaboration with development partners, NGOs and CBOs.

**Figure 4.1 : NRHM BCC Strategy, Uttar Pradesh**



---

## BCC Interventions

The NRHM BCC strategy for Uttar Pradesh proposes interventions at the following levels:

- State
- Facility/institution
- Local/village-slum
- Household/family

These interventions are linked together by a common strategic plan that includes a planned focus on a set of priority behaviours. However interventions at the household and facility levels will provide need based BCC that will include a much larger set of behaviours. Figure 4.2 describes all the interventions proposed for BCC inputs for NRHM in Uttar Pradesh.

### ▪ State Level

The interventions at the State level include airing TV, radio spots, health related serials etc., celebration of health days, implementing mass campaigns ranging from 3-4 months to 1 week, initiating use of alternate media such as cell phones using SMS campaigns and contests.

Political & Media Advocacy and use of outdoor media such as bus and autorickshaw panels, hoardings etc. are also recommended.

### ▪ Facility/Institution

BCC interventions at health facilities and schools are described in Figure 4.2. There will be a family counsellor equipped with audio visual tools for counselling on Maternal & Child Health, Family Planning and other national Programs available at each block PHC who would be a key BCC resource person to provide counselling on postnatal care of mother, new born care and family planning to JSY beneficiaries at the PHC. In addition, “*Badhai*” kits will be given to every mother-child pair on discharge from the institution. The wall paintings at the institutions will include the following: services available at the facility with rates, details of JSY, names of Medical Officer (in-charge) and their phone numbers.

### ▪ Community Based BCC Interventions

Community level BCC interventions include group meetings, VHND, community notice boards, use of short films, “CD Spots” etc. Details of the group meetings conducted by ASHAs and ANMs are provided in Annexure 7 and 8. Other community based activities include felicitation of good ANMs, community “*baithaks*” to review the work. The strategy proposes use of village level and household level monitors to track service provision and service utilization at the household level. A VHND help line is proposed and people can call the helpline to complain if the VHND is not held in the village as planned. The village notice board will have the monthly schedule for the VHND.

### ▪ Household/Family Level (Interpersonal Communication)

Home visits by ASHA to eligible women and pregnant women are recommended. An IPC (interpersonal communication) tool for maternal and newborn health is being suggested to enable ASHAs to do need specific BCC at the household level.

Other household level BCC interventions include child to community approaches and promoting couple and family communication.

Figure 4.2

## BCC Interventions

State	Facility/Institution	Village/Slum	Household/Family
<ul style="list-style-type: none"> <li>• Mass Media</li> <li>• Short Films/CD Spots</li> <li>• Posters etc.</li> <li>• Outdoor Media</li> <li>• Folk Performances</li> <li>• Swasthya Melas</li> </ul>	<ul style="list-style-type: none"> <li>• <b>PHC:</b> Short Films/ CD Spots</li> </ul>	<ul style="list-style-type: none"> <li>• Short Films/ CD Spots</li> </ul>	<ul style="list-style-type: none"> <li>• ASHA Home Visits</li> </ul>
	<ul style="list-style-type: none"> <li>• <b>PHC:</b> Posters/Leaflets</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly Group Meetings ASHA/ANM</li> </ul>	<ul style="list-style-type: none"> <li>• ANM ANC Service and VHND</li> <li>• ANM PNC Visit</li> </ul>
<ul style="list-style-type: none"> <li>• Celebration of Health Days</li> </ul>	<ul style="list-style-type: none"> <li>• <b>FRU:</b> Family Counsellor</li> </ul>	<ul style="list-style-type: none"> <li>• Khusali Diwas (VHND)</li> </ul>	<ul style="list-style-type: none"> <li>• Couple Communication</li> <li>• Family Communication</li> </ul>
<b>Mass Media Campaigns</b> <ul style="list-style-type: none"> <li>• Behaviour Change <ul style="list-style-type: none"> <li>■ Maternal Health and Nutrition</li> <li>■ Child Health and Nutrition</li> <li>■ Adolescent Health and Nutrition</li> <li>■ Family Planning</li> <li>■ Hygiene and Sanitation</li> </ul> </li> <li>• Provider Change</li> <li>• Gender</li> </ul>	<ul style="list-style-type: none"> <li>• <b>PHC/CHC</b> Display Boards Wall Painting</li> </ul>	<b>Local Events</b> <ul style="list-style-type: none"> <li>• Saas bahu Sammelan</li> <li>• Recipe Competition</li> <li>• Panel Discussions</li> <li>• Role Plays</li> <li>• Poster Competitions</li> <li>• Couple Workshops</li> <li>• Folk Performances</li> </ul>	<ul style="list-style-type: none"> <li>• Child to Community</li> <li>• Child to Family</li> </ul>
<b>Alternate Media:</b> <ul style="list-style-type: none"> <li>• ASHA Helpline</li> <li>• VHNB Helpline</li> <li>• SMS contests</li> <li>• Post Card or JSY Beneficiaries</li> </ul>	<b>School</b> <ul style="list-style-type: none"> <li>• School Health Programmes</li> <li>• Anaemia Prevention for Adolescent Girls</li> </ul>	<ul style="list-style-type: none"> <li>• Village Health &amp; Sanitation Committee Monthly Meeting</li> </ul>	
<ul style="list-style-type: none"> <li>• Bus/Rickshaw Panels Banners</li> </ul>	<b>School</b> <ul style="list-style-type: none"> <li>• Child to Family/ Community</li> </ul>	<ul style="list-style-type: none"> <li>• Community Networks NGOs</li> <li>• Mahila Samakhya CBOs</li> </ul>	
<ul style="list-style-type: none"> <li>• <i>Shubh Vivah</i> Kits</li> <li>• <i>Badhai</i> (MNH) Kits</li> </ul>		<ul style="list-style-type: none"> <li>• <b>Community Notice Boards</b></li> <li>• Gram Panchayat,</li> <li>• ASHA house etc.</li> </ul>	
<b>Advocacy - Media and Political</b> <ul style="list-style-type: none"> <li>• Press</li> <li>• TV</li> <li>• Faith Based Organisations</li> <li>• Public Representatives</li> </ul>			

---

## A. Interpersonal Communication (IPC) & Community Level BCC Activities

There are many health related behaviours but they can be divided into two broad sets. One set of behaviours occur within the microenvironment of the home e.g. hygiene and dietary behaviours; condom use, oral pill use etc.; the other set of behaviours requires contact with the health delivery system e.g. antenatal check ups, routine immunization, sputum testing etc. Behaviours occurring within the micro-environment of the household can be changed irrespective of the availability or accessibility of health services<sup>26</sup>. In the case of health seeking behaviours, government health services have to be made accessible, available and of good quality, for people to use them consistently and BCC needs to address health service barriers.

### Why IPC & Community Level BCC Approaches?

A study estimates that a total of 18 contacts with mother and child over five years (3 contacts per year) can **“deliver effective child survival interventions, almost entirely through community based and outreach delivery efforts”**

Haines, A. et al (2007) “Achieving Child Survival Goals: Potential Contribution of Community Health Workers”

This BCC strategy proposes changing household level behaviours through focussed community based interventions at the community, group and household levels in addition to mass media inputs. Health service utilization will increase through the provision of persuasive inputs and local details of time, place and venue of services;

The proposed community based BCC activities are:

- (1) VHND / Khushali Diwas
- (2) Home visits by ASHA to offer need specific BCC.
- (3) Group meetings by ASHA and ANM on specific topics
- (4) Swasthya Camps at the block level with video vans (Pilot basis)
- (5) Child to community BCC for hygiene behaviours, routine immunization and prevention of mosquito breeding sites
- (6) Folk performances and Nukkad Natak

The VHND and home visits by ASHA are the main community level BCC strategies being proposed. Every effort must be made in the first year of strategy implementation, to ensure and monitor that these two activities are initiated and regularized. Detailed plans have been worked out for these two strategies.

#### ▪ The Village Health and Nutrition Day (VHND)

One of the biggest barriers to maternal health and immunization coverage in rural Uttar Pradesh has been the lack of regular outreach services at the village level. NRHM has proposed a monthly Village Health and Nutrition Day. The VHND should be planned as a day for ensuring ANC and RI service utilization, promoting family planning and enabling community accountability by regular monitoring of the VHND by the village health and sanitation committee. The VHND will be conducted in two parts. The first part focuses on service provision and the second part focuses on BCC. A detailed description of the VHND strategy is provided below. Eight different local events are outlined and these should be held every month along with the VHND. Many other events can be added according to local need and initiative. The BCC strategy proposes the following components in the VHND:

---

<sup>26</sup> Haines, A. et al (2007) “Achieving Child Survival Goals: Potential Contribution of Community Health Workers”  
Lancet Vol 369 June 23 pp 2121-2131

**Table 4.3: VHND**

<b>Khushali Diwas (Village Health and Nutrition Day)</b>
<b>Wednesday or Saturday (every month)</b>
<b>Part I: Health Services</b>
<b>Morning 10 am to 1.00 pm</b>
<ul style="list-style-type: none"><li>▪ 5-6 School Children to be involved in mobilizing mothers of infants for the RI session according to plan and need; Rallies at village level by school children (Bulawa tolis)</li><li>▪ ASHA to mobilize pregnant women and women/couples intending to use contraceptives;</li><li>▪ AWW to mobilize parents of children under three years for weighing</li><li>▪ Contract private practitioner for FP counselling and provision of FP services at each VHND<ul style="list-style-type: none"><li>○ RI Session conducted by ANM</li><li>○ TT to pregnant women by ANM</li><li>○ ANC check up conducted by ANM</li><li>○ IFA distribution by ANM</li><li>○ Weighing of under-threes by AWW</li></ul></li></ul>
<b>Part II: BCC Group Meeting and Local Community Event/s</b>
<b>Afternoon 2 to 4 pm: Women's Group Meeting by ANM (for details refer Annexure 7)</b>
<b>Evening 5 to 7 pm:</b>
<ul style="list-style-type: none"><li>▪ Local Event organized by MPW and Village Health and Sanitation Committee. Illustrative list of activities that can be planned for the community event given below:<ul style="list-style-type: none"><li>○ Male Meeting to encourage discussion on male responsibility, Family Planning, NSV, Birth preparedness</li><li>○ Panel Discussion on Emergency Transportation</li><li>○ Viewing a Film and Group Discussion on selected topic</li><li>○ Saas Bahu Sammellan</li><li>○ Couple Workshop</li><li>○ Recipe Competition &amp; discussion on Nutrition</li><li>○ Discussion on JSY, need for ANC, Identification of danger signs</li><li>○ Skits performed by village girls / boys on gender issues, right age of marriage, need to delay the first birth</li><li>○ Poster competition amongst school children on hygiene &amp; safe water practices, Routine immunization</li><li>○ Speech Competition on "What We Can Do to Save Maternal and Newborn Lives in Our Village" etc.</li><li>○ Felicitation of service providers</li></ul></li></ul>
<b>Human Resource for Khushali Diwas (VHND): ANM, AWW, MPW, ASHA, 5-6 school children, Village Health and Sanitation Committee members, village volunteers.</b>

---

#### ▪ ASHA Home Visit

One of the most important elements of the NRHM has been the policy to introduce an ASHA at the village level for every 1000 population. Most of the policy makers interviewed requested that a more specific BCC role for the ASHA be defined. Programs with a specific focus such as Comprehensive Child Survival Programme (CCSP) are being implemented in a phased manner in the state. It will be important to adapt the lessons learnt from these programs to further modify/enhance the ASHAs home visit schedule. CCSP is already implementing a detailed home visit schedule in the 17 districts where it is currently operational.

The ASHA, a community based health activist, is the mainstay of the NRHM programme in the EAG (Empowered Action Group) states. Evidence from NGO led programs and studies as well as from other countries like Brazil, indicate that a community based agent like the ASHA can help achieve the goals of prevention and reduction of maternal and neonatal mortality<sup>27</sup>. More than half the stakeholders consulted during the preparation of this report also felt that the core role of the ASHA lies within the BCC work sphere and that her BCC skills at the household and community levels should be developed. Therefore, the behavioural change aspect of the BCC programme centres around the ASHA with support from the community, other providers and the media.

The availability of a grassroots worker for health enables the provision of need based BCC at the family level. Communication skills are required for effective BCC at the household level are: compassion (*sahridaya*), asking questions (to assess need), listening, observation (does the household use a dipper for pouring drinking water, which vegetables, pulses, cereals are locally available, location of soap etc.), establishing dialogue and arriving at a consensus for action. Follow-up inputs to the household are necessary to enable the individual/household to sustain behavioural change.

A recent Johns Hopkins University and Lucknow School of Medicine study has also indicated that the strategy of two home visits during the antenatal period and two home visits during the post natal period has been crucial in achieving reduction in maternal and neonatal mortality. The Institute of Health Management, Pachod adopted a fixed day focussed household visit approach (two household visits a month) in 2003-2006 and increased use of temporary contraception from 8 percent at baseline to 30 percent at end line <sup>28</sup>.

The advantage of emphasizing community based approaches such as home visits in addition to mass media campaigns is that it allows for direct BCC interaction at the time when it is most relevant to the family. For example trimester-wise and need based inputs can be provided to pregnant women and essential new born care can be promoted when the woman has a neonate.

---

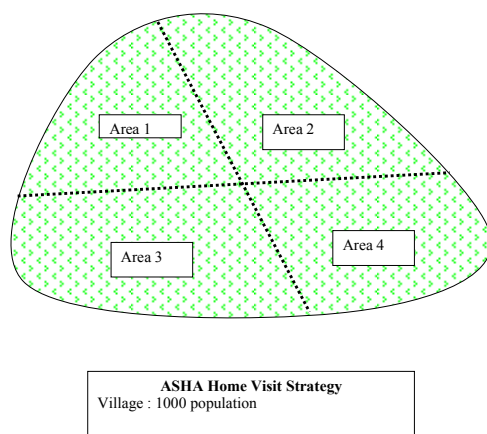
<sup>27</sup> Brazil, 2004.

V. Kumar et al (2008) forthcoming in Lancet "Impact of community based behaviour change management on neonatal mortality, a cluster randomized control trial in Uttar Pradesh, India"

Bang, AT and Bang, RA et al (1999) "Effect of home based neonatal care and management of sepsis on neonatal mortality: field trials in rural India". Lancet, 354 pp 1955-1961

<sup>28</sup> IHMP (2007) "Improving the Health of Married Adolescents in a Rural and a Urban Slum Site in Maharashtra"

**Figure 4.4 ASHA Home Visit Strategy**



### **Interpersonal Communication Tool for ASHA Home Visit**

A simple IPC tool to enable the ASHA to provide need specific, situation specific BCC is being proposed in this strategy document. This tool has been used by the Institute of Health Management Pachod in Maharashtra and has been pilot tested in both rural areas and urban slums. IHMP has been using this tool for the last 10 years.

The tool is low cost and being light in weight, is easy to carry from house to house.

Villages in Uttar Pradesh are usually divided into 3-5 “tolas” (areas) such as Chamar tola, Bania tola, Brahmin tola (Figure 4.4). The ASHA has to cover all areas in her village. It is proposed that ASHA conducts her visits “tola” or area wise to facilitate complete coverage of her village in a month. A monthly home visit plan should be developed for each ASHA during the monthly meeting at the PHC. A format for the home visit plan can be developed and the block BCC officer should be in charge of its supervision and implementation of the monthly plan.

The ASHA home visit schedule has been worked out so that it covers the following services - women’s health, maternal health, new born health, child health and family planning. A pregnant woman gets three ANC home visits by the ASHA and two PNC home visits (refer box). IPC on neonatal care, exclusive breastfeeding, and routine immunization would be given.

The primary audience for the ASHA home visit would be households with eligible couples (i.e. couples in reproductive age who have not adopted a terminal method of family planning). It is hoped that an ASHA has at least 6 contacts per year per eligible couple. This would enable the ASHA to address the various health needs of these households. In addition, the home visits by the ASHA to eligible couples would enable focussed IPC on various temporary contraceptive methods like OCPs, IUDs, Condoms, Cycle beads, Lactational Amenorrhea Method (LAM), Emergency contraceptives etc.

In addition, it is suggested that the ASHA makes contact with the newly married couples in the village to counsel them on family planning, giving them a *Shubh Vivah* kit containing literature on Gender issues, need to delay the first birth, importance of couple communication and information on spacing methods. The kit would also include bangles, *kumkum*, *binds* for women, and set of contraceptives (15 condoms and two cycles of Oral Contraceptive Pills)

If an ASHA is to reach every eligible couple in her village about six times a year, she has to visit approximately 60 households a month. In addition she has to visit about 16 pregnant women a month; and do about four post natal home visits a month. On an average, she has to visit about 70 households a month. Initially, based on the SIFPSA experience of the CBD projects, a total of 50 home visits per ASHA on a monthly basis is being proposed. In addition, a simple diary for self monitoring and random checks by the block level supervisory Health Education Officer is being proposed as a monitoring tool for the monitoring of the ASHA home visits.

The state has already initiated an ASHA motivational program through the Best ASHA Reward Scheme at the block level giving a cash award of Rs. 5000/- for the ASHA. The ASHAs are awarded at a district level public function on the ASHA Diwas to be held annually on 23<sup>rd</sup> August across the state.



In addition, a quarterly ASHA newsletter has also been initiated which will be used as a motivational tool for the ASHAs

#### Estimation of Workload for ASHA for 1000 population

- Total population = 1000
- Married couples = 180
- Pregnant women = 30
- Sterilized couples = 30
- Eligible couples = 120

#### ASHA Home Visit Strategy

- 6 Home Visits per eligible woman/year
- 3 ANC Visits per pregnant woman
- 2 PNC visits per mother and newborn

#### Monthly BCC Workload for ASHA

1. Home Visits: 4-5 HHs/day/2 days a week (Total of 50 HV monthly)
2. VHND: once a month
3. Group Meeting: Once a month
4. Delivery Cases: Twice a month
5. PNC Cases : 2/month
6. Village Health and Sanitation Committee meeting: 1/month

**Table 4.5**  
**ASHA Home Visits (HV)**

#### Pregnant Women

- HV 1: Registration
- HV 2: Check-ups, Recognition of ANC danger signs
- HV 3: Birth Planning

#### Post Natal Care

- HV 1 (within 48 hours) Recognition of danger signs in mother & neonate
- HV 2 (3-7 days): Identification of sick newborns

#### Eligible Women (non sterilized, non-pregnant women)

- HV 1: Assess need and recommend temporary or terminal FP methods; if child under 3 years assess diet, immunization coverage, hygiene and growth patterns; Provide BCC accordingly
- HV 2: Follow up on previous visit; Assess barriers to FP use; same as above
- HV 3: Assess other RH needs; BCC on diet; same as above
- HV 4: Assess other RH needs: BCC as per campaign theme
- HV 5 : Assess other RH needs: BCC as per campaign theme
- HV 6 : Assess other RH needs: BCC as per campaign theme

#### Anganwadi Worker's BCC Role

The AWW has a well defined set of activities and tasks to perform within the ICDS programme. During the monthly VHND, the AWW is responsible for weighing all children under three years. This gives her an opportunity to interact with the child's caretaker on crucial issues of the child's diet, nutrition and recent morbidity. The AWW can be trained in identifying the need of each child and providing situation specific BCC based on each child's need. If the AWW's BCC skills are upgraded, the effectiveness of her IPC and group activities will increase. The AWWs should also be oriented on behaviour focussed BCC inputs.

---

## B. Community Mobilization and Community Accountability

Several studies are now highlighting the fact that it is not just lack of demand for government health services that results in low service utilisation but that government health services are simply not available<sup>29</sup>. BCC has to play a role in awakening community response to ensure that community health services crucial for maternal and new born health are available. Community entitlement is a core component of NRHM. There is an expert advisory group for NRHM on community action. The NRHM website has samples of 25 poster/pamphlets on various aspects of community entitlement such as basic PHC services, the Village Health and Nutrition Day (VHND), the role of the Village Health and Sanitation Committees, the grant provided to the sub-centre etc.

There are many areas where community involvement can address basic barriers to behaviour change. Often there is no emergency transport available. At yet another level, the households that have no food security are the most disadvantaged. The Village Health and Sanitation Committee could be given a priority agenda to address these two concerns: (1) organizing emergency transport and (2) monitoring the needs and service coverage of the most marginalized households

The operationalization of the concept of “community entitlement and monitoring” is planned through the establishment of community notice boards, a big village level growth card for children less than three years, display of norms and services available at sub-centre, primary health centre and CHC and community monitoring through a household level calendar.

### **Community Notice Boards, Community Growth Card, Community Report Card**

The regular provision of monthly maternal and RI (routine immunization) services at the village level will be highly dependent on community demand and community monitoring. NRHM states that one monthly Village Health and Nutrition Day (VHND) has to be held in every village. It is proposed that the scheduled date and time of the VHND should be posted on 2-3 notice boards across the village. These posters should also carry a number to complain to in case the VHND is not held as per schedule. Other important information and posters can be posted on the notice boards.

Similarly, a giant community growth card can be placed at the Gram Panchayat office or school and the levels of malnutrition of all the children under three years can be collectively monitored by the community.

The work that is necessary for effective BCC, cannot be done by health service providers or ASHA or mass media channels alone. Communities have a major role to play in driving and sustaining behavioural change. Community resources can be mobilized to demand the provision of health services and to ensure that services are provided. The strategies utilized to organize and mobilize these community resources will determine the effectiveness of the community mobilization efforts.

Two broad strategies for community mobilization are recommended:

1. Working with specific local resources on an on-going basis and assigning defined community mobilization and monitoring roles and tasks. Building their capacity to demand and monitor health services and to ensure health service utilization.
2. Working with and liaising with various local groups and structures to widen the reach of persuasive communications to important audiences. These local groups can create extensive communication networks by discussing various health behaviours within their groups and

---

<sup>29</sup> A study in Uttar Pradesh found that 42 percent health care worker at primary facilities were absent during random checks (Chaudhary, Hammer et al, 2003). Similarly a recent survey by Transparency International India, Centre for Media Studies of 22728 BPL households nation wide found that the poorest have to pay bribes totally Rs 87 crores to avail of government health services (Transparency India International, 2008)

---

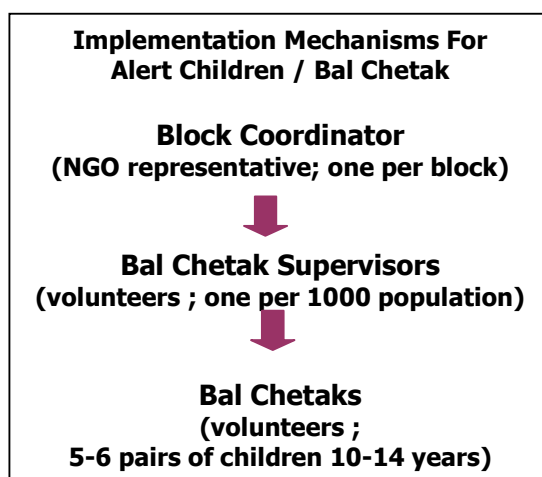
beyond them too. The members of different networks will in turn “persuade” and influence their own families and/or neighbourhoods to adopt healthy behaviours.

- **Community Mobilization Strategy 1 (a) The “Bal Chetak” Intervention to increase percent of children (12-23 months) fully immunized from 22 percent to 50 percent**

Few development programs consider children as change agents. Child Centred Development has the potential to transform both children and communities. Research undertaken by IHMP indicate that children have successfully changed hygiene and sanitation habits of villagers, improved the village environment, promoted dietary change in adolescent girls and developed leadership skills in themselves<sup>30</sup>. In addition, villages that participated in the IHMP’s Bal Vikas programme had lower school drop out rates at the primary and secondary levels than villages that did not have the Bal Vikas programme. Children can be organised to promote the development of their communities in the areas of health, education, water, sanitation, afforestation & environment.

The Bal Chetak or the Alert Children intervention (child-to-community) is also planned as a community led strategy for increasing RI coverage. Initially the Bal Chetak intervention can be piloted in Mahila Samkhaya districts using the village level supervisor of Mahila Samkhaya for organising the children. In the meanwhile, linkages with the Department of Basic Education should be strengthened to take the Bal Chetak intervention to scale.

The Bal Chetaks can be motivated by a commendation certificate given to those Bal Chetaks who have ensured the complete immunization of a minimum of 5 children per year. The commendation certificates could be given away to children on the occasion of the Children’s Day held annually on 14<sup>th</sup> November at a public function. The performance of the supervisors of the Bal Chetaks can also be acknowledged at the same function.



---

<sup>30</sup> Kapadia-Kundu (1994) *An empirical test of the Sadharanikaran theory of communication to defecation hygiene behaviour: An evaluation of a child-to-community intervention in Maharashtra, India. PhD Dissertation submitted to Johns Hopkins School of Hygiene and Public Health, Baltimore.*

<b>Table 4.6</b> <b>Using Bal Chetaks for community mobilization for Routine Immunization</b>	
<b>Who is a Bal Chetak</b>	A Bal Chetak is a child volunteer (10-14 yrs). The Bal Chetaks will work in pairs. They will track 4-5 infants living in their neighbourhood from birth to one year in the initial phase of the programme.
<b>Bal Chetak's role</b>	<ol style="list-style-type: none"> <li>1. Maintain a book with the names and immunization coverage of average 4-5 infants in their area.</li> <li>2. Provide a home visit two days prior to the VHND to inform parents of infants about RI session in village. Alert their supervisor, if parents are resistant.</li> <li>3. Bal Chetak's to check the infant's immunization card during the home visit and mark its current status in their record book.</li> <li>4. Bal Chetaks to make home visit to the 4-5 infants under their care on the morning of the VHND session. Provide information on alternative options in case the family is not able to come to the session.</li> </ol>
<b>Bal Chetak's Schedule</b>	<ul style="list-style-type: none"> <li>• Three home visits a month per pair to 4-5 homes with infants               <ol style="list-style-type: none"> <li>a. Home visit 1: 2 days prior to the VHND</li> <li>b. Home Visit 2: Morning of VHND</li> <li>c. Home Visit 3: One day after VHND</li> </ol> </li> <li>• Monthly review meeting with the Bal Chetak Supervisor (Fixed time / date/ place)</li> </ul>
<b>Criteria for Selection of Bal Chetaks</b>	<ul style="list-style-type: none"> <li>• Child (10-14 years) with good communication skills</li> <li>• Equal numbers of pairs of girls and boys</li> <li>• Child should be residing in the neighbourhood allotted to her/him</li> <li>• Child should be willing to become a Bal Chetak</li> <li>• Child can be selected by either NGO or school based on above criteria only</li> <li>• There will be approximately 5-6 pairs of Bal Chetaks per 1000 population</li> </ul>
<b>Bal Chetak Incentives</b>	The Bal Chetak is a child volunteer and will receive no cash incentives. Instead a system where community service is rewarded should be devised. This could be in the form of special certificates of recognition, a system that awards stars, study tours, scholarships, felicitation etc.
<b>BCC Materials for Bal Chetak Intervention</b>	<ul style="list-style-type: none"> <li>• Orientation package for supervisors</li> <li>• Cards for home visits</li> <li>• Home calendar</li> <li>• Bal Chetak record keeping book</li> </ul>






<b>Table 4.7</b> <b>Bal Chetak Supervisor</b>	
<b>Coverage Area</b>	One supervisor for 1000 population (5-6 pairs of children)
<b>Criteria</b>	<ul style="list-style-type: none"> <li>• Should be a resident of the village</li> <li>• Can be a Samiti member, Shiksha Mitra, youth volunteer, retired school teacher , NGO worker etc.</li> </ul>
<b>Responsibility</b>	<ul style="list-style-type: none"> <li>• The supervisor works in a voluntary capacity</li> <li>• Should be able to select, train and provide continuous guidance.</li> <li>• Supervisor has to allot areas and keep track of new births from ASHA and allot them to Bal Chetaks.</li> <li>• Maintain a record of the overall immunization coverage in the village</li> </ul>

### “Indradhanush” - Colour coded BCC strategy for RI for Bal Chetaks & Community

BCC initiatives in RI pose a challenge because of the number of vaccines, varying doses per vaccine and differing time intervals between doses. Add to that, the number of booster doses and the list is quite formidable. Often the main behavioural message gets lost in a large clutter of information.

Sadharanikaran enables the design of simple, easy to comprehend, persuasive inputs to enable infants to be immunized. The BCC strategy proposed for RI will simplify the RI campaign through a colour coding mechanism that focuses on “5 contacts per year”. The colour coding will facilitate comprehension and recall as most people are familiar with basic colours while they may not recognize terms such as “DPT” or “booster” etc. The Bal Chetak strategy planned for providing persuasive inputs for RI will also ensure a level of simplification as child communicators

**Table 4.8**

<b>Colour Coded BCC Strategy for RI for Bal Chetaks / Community</b>	
<b>Key Behavioural Focus :</b> 5 contacts a year for complete immunization of an infant	
	1st Contact (Violet/Baingani): BCG, zero polio
	2nd Contact (Blue/Neela) DPT1
	3 <sup>rd</sup> Contact (Green/ Hara) DPT2
	4 <sup>th</sup> Contact (Yellow/ Peela) DPT3
	5 <sup>th</sup> Contact (Orange/Narangi) Measles
<b>TV/CD Spots/Radio Spots</b>	
Focus on 5 contacts a year for an infant; Colour coded for ease of retention. For example: contact 1 – Violet; contact 2 – blue; etc. The colours are drawn from the VIBGYOR colours so that the inclusion in the academic curriculum for the children is also easier.	
Spot showing Bal Chetak (10-14 yrs) motivating parents and bringing them for RI session; child shown explaining to parents when the next vaccine is due. Bal Chetaks assuring parents that she/he will be with them; Bal Chetak telling ANM didi that she must come regularly for the RI session. Bal Chetak telling parents that RI is a free service.	
<b>Facility Level</b>	
Badhai kit with RI schedule to be given to JSY beneficiary prior to discharge	
Reminder postcards (colour coded)	
<b>Community Level</b>	
Notice Board: VHND schedule	
One Group Meeting per year by ASHA on RI	
<b>Bal Chetak Strategy</b>	
There are about 30 infants in a population of 1000. One pair of Bal Chetaks to take responsibility of 5-6 infants each. Bal Chetaks to maintain a separate colour coded RI format for the infants under their care. Mahila Samkhaya supervisor/ Shiksha Mitra/ AWW/ NGO worker to coordinate this activity.	

---

▪ **Community Mobilization Strategy 1(b) Using Village Health and Sanitation Committee (VHSC) to promote maternal & neonatal health and manage outbreaks**

Much has been written and said about the role of the Village Health and Sanitation Committees and community mobilization. This strategy proposes a focussed three point agenda for the committee to work with in the first three years.

- Saving maternal and newborn lives
- Ensuring equitable health services and resources to the poorest households in the villages
- Prevention and management of outbreaks

The following steps are suggested to develop a strong community led model of people's involvement:

- Ensuring adequate representation by villagers/community members in addition to the elected members. One female and male representative should be nominated by the people from each part (tola / mohalla) of the community. This will involve conducting a meeting in each part of the village (4 to 5 meetings depending on the size of the village).
- Orientation of the committee members.
- Facilitation of the monthly VHSC meeting by NGO or Mahila Samakhya representative.
- The orientation/ capacity building of the NGO and Mahila Samakhya workers on facilitation of democratic functioning of the committees.

**Proposed role of the Village Health and Sanitation Committee:**

1. Ensuring complete antenatal check ups and institutional deliveries. Here their main role would be organizing means of transport - both emergency and for delivery. The committee will have to draw upon local resources to work out a locally appropriate solution.
2. The committee has to maintain a list of marginalized households and make sure that the neediest households have access to and avail of ante-natal and anganwadi services.
3. The committee has to work out a vigilance and outbreak detection and management plan. It's capacity will have to be built with technical assistance but primarily it will have to deliberate on the health profile and history of the village/community and identify potential outbreaks and mechanisms to prevent them. They must also have a plan in place to manage an outbreak in case one should occur in their village. This would be along the model of "disaster preparedness". This is most essential in districts where outbreaks of vector borne diseases are endemic.

<b>Table 4.9</b> <b>Monthly Monitoring by Village Health &amp; Sanitation Committee</b>	
<b>Maternal Health</b>	<ul style="list-style-type: none"> <li>• ANM Visit to village as per schedule</li> <li>• VHND held on schedule</li> <li>• Number of Institutional deliveries and Home deliveries in the village in a month</li> </ul>
<b>Health Services for the marginalized</b>	<ul style="list-style-type: none"> <li>• Monitor linking of food insecure households to the Anganwadi Centre</li> <li>• ASHA conducting home visits to the marginalized households</li> <li>• Holding of group meetings for women from marginalized households</li> <li>• Whether contraceptive needs, child health needs etc. have been met for marginalized households</li> <li>• Assessing how many children in the village are malnourished (degrees 2 and 3). Of these, how many are from marginalized households</li> </ul>
<b>Outbreak Prevention and Management</b>	<p>In the context of outbreak prevention and management the NGO/support agency has to provide the following inputs to the village health and sanitation committees:</p> <ul style="list-style-type: none"> <li>• Assess village needs and vulnerability to outbreaks</li> <li>• Identify breeding sites of vectors</li> <li>• Identify sites of unclean drinking water</li> <li>• Develop a local plan to destroy/control breeding sites</li> <li>• Assess the most feasible interventions – bed nets/spraying/emptying water containers etc.</li> <li>• Use a child-to adult strategy to promote the interventions (especially emptying of water containers on a weekly basis; a DOTS type of an approach can be used)</li> <li>• Nominate a person who will manage the control of outbreaks. Prepare a plan to manage outbreaks. Who should people alert in case of an outbreak.</li> </ul>
<b>BCC training tools for developing capacity of the VHSCs and local groups</b>	<ul style="list-style-type: none"> <li>• CD films on functioning of the committee; highlighting the committee's role in the VHND</li> <li>• TV, radio and CD spots on the role of the committee in prevention and management of outbreaks.</li> </ul>

#### **Partnering with NGOs / Mahila Samkhya for capacity building of VHSCs:**

In areas where NGOs or organizations such as Mahila Samkhya are working, they can be asked to assume the role of building capacity of the VHSC members and ensuring demand creation within the community for health services. It is recommended that this model should be piloted in areas where outbreaks are likely to occur with two models:

- In collaboration with NGOs
- In collaboration with the Mahila Samkhya districts

---

Mahila Samkhaya performs the dual function of enabling equity and empowering women. Currently working in 17 districts in Uttar Pradesh, their mandate is to strengthen and empower women especially in the most marginalized segments of society. Building capacity of these existing networks to work with the VHSC will be a first step towards actualising the NRHM doctrine on peoples' involvement and health rights.

▪ **Community Mobilization Strategy 2: Working and Liaisoning with Different Local Groups and Networks**

The second strategy for community mobilization is broader and requires the engagement of different stakeholders and groups. The strategy can be operationalized only if some one is assigned the specific responsibility for implementing the task of working with local groups and networks. Working with local groups and networks will have to be done at the state and district levels. NGOs can also be involved. However the important issue is that liaisoning with different local groups should be in consonance and coordination with the defined NRHM BCC strategy. Communities need mechanisms through which they can be mobilized and activated. These mechanisms vary in different community settings and can be mobilized in several ways.

The following community resources are available:

- Women's groups
- Mahila mandals
- Farmers clubs
- Youth groups
- Children 6-14 years
- Shiksha Mitras
- Gram Panchayat members
- Village Health and Sanitation Committee members
- CBOs
- Truck and auto-rickshaw unions (urban areas)
- Factory workers
- Interested citizens - women, mothers-in-law, men, adolescent girls and boys etc.

A definite strategy needs to be adopted when working with local groups and networks. Otherwise the networking is diffuse and general with little or no measurable outcomes. The strategy document provides an opportunity to define a specific focus to the local networking efforts. The suggested role includes:

1. Demanding health services and monitoring its availability
2. Establishing new social norms in group settings like through pledges, signing community resolutions etc. New social norms can be set for the following behaviours:
  - Institutional delivery
  - Marrying girls above 18 years
  - Hand washing with soap after defecation
  - Three ANC check ups for pregnant woman
3. Adopting healthy behaviours for themselves, their families and motivating their neighbours and kinship networks to do the same.

NGOs would be effective in the local advocacy "environment building" efforts. The tasks required at the state and district levels are:

- Identifying and preparing lists of community groups and organizations per district (list of possible groups provided in above section)
- Conducting orientation workshops with community groups. These workshops should have defined outcomes and follow ups; with different community groups
- Using campaign materials to develop BCC kits for the workshops



- Develop specific behaviours that the group has to adopt and recommend to their families, peers and neighbours.

Another crucial role that community groups such as VHSC, youth clubs, mahila mandals, CBOs etc. can play is that of organizing traditional, local and mid media events at the community level. It is recommended that this strategy be piloted in a few districts.

## C. Mass Media Campaigns

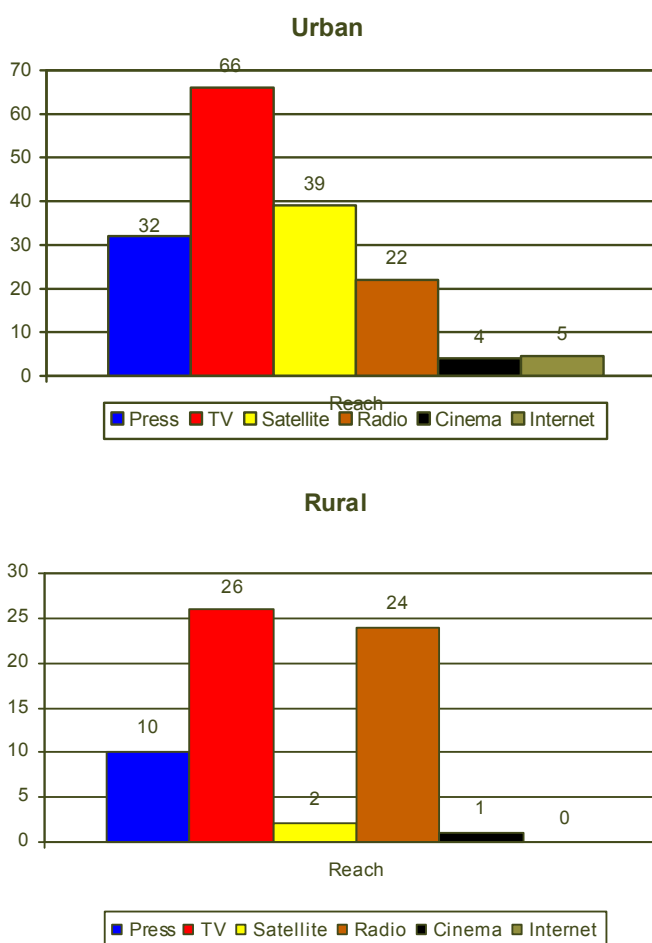
The optimal role of mass media to meet health related behavioural objectives is still evolving in a constantly changing world. The relevance of traditional concept of “TV and Radio” public service advertisements is debatable in a scenario where multiple TV channels and media clutter co-exist. Often the “message” reaches the “wrong” audience (eg. FP commercials for rural audiences being aired on Discovery channel etc.). Today the corporate sector is utilizing newer techniques such as “branded entertainment” “on-line video ads” “interactive advertising” etc.

### Limited Media Reach:

A major constraint in implementing mass media campaigns in Uttar Pradesh is the low media reach in the rural areas. Combined television reach of all channels in rural UP is a mere 26 percent while radio reach is at 24 percent (Table 4.10). The low reach of electronic media is compounded by the poor electricity supply situation in rural UP. Local cable channels are available but have seldom been used extensively in the past due to the unorganised nature of cable operations.

The incremental reach across all television channels and Radio is 40 percent in rural UP while with Doordarshan and Radio is 38 percent (Table 4.11)

**Table 4.10**  
**Reach of Mass Media Channels in UP**



*Source: IRS R1 2007*

<b>Table 4.11</b> <b>Incremental reach of mass media channels in Uttar Pradesh</b>					
	<b>TV</b>	<b>TV + Print</b>	<b>TV + Radio</b>	<b>Doordarshan</b>	<b>Doordarshan + Radio</b>
Urban	66	71	71	-	-
Rural	26	30	40	24	38
<i>Source: IRS R1 2007</i>					

Therefore in order to cost effectively extend the reach of traditional electronic media such as radio and TV in conjunction with local cable channels, the BCC strategy proposes the use of alternative technologies such as battery operated VCD players with monitors; CD players etc.

Kaiser Foundation has released a series of case studies on “New Media and the Future of Public Service Advertising” that demonstrate the use of newer media and technology to meet the goals of health and development programs. They state, “PSA campaigns face critical challenges to stay relevant and effective”. The publication features an Indian PSA campaign by the AVAHAN project that uses SMS and text messaging for HIV education and behaviour change. The multi media campaign included a number to call leading to the following options: (1) getting a fact related to HIV/AIDS (2) how to contact a helpline and (3) a contest<sup>31</sup>.

There is need for innovation in the way we conceive and plan media campaigns for public health. In addition to the traditional mass media channels, this strategy proposes three alternative media strategies that can bolster planned media campaigns. These are:

### **What is a CD Spot (short films)?**

This strategy proposes the development of 3-7 minute “CD Spots” (short films) to extend the reach of electronic media. The issue of media exposure through traditional media channels like TV and radio is complicated with regular power cuts in rural areas, the introduction of competing channels and low media reach in rural areas. On the other hand, portable battery operated VCD players and other electronic devices offer alternative mediums of reaching the same BCC motivational content to rural audiences. In fact the audiences can be segmented by need, risk, level of marginalization etc.

The CD spots can be played at facilities, group meetings, mass meetings, large scale programs such as melas etc. They can also be played in schools etc. Similar to the concept of CD spots is another simple medium, using power point and multi-media presentations as training and AV aids.

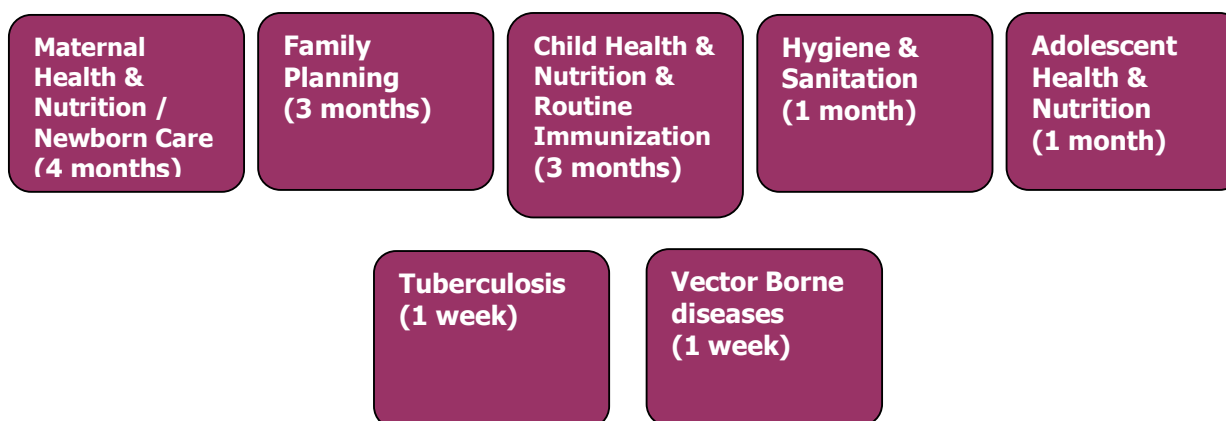
<sup>31</sup> Kaiser Family Foundation (2006) “New Media and the Future of Public Service Advertising: Case Studies” at <http://www.kff.org/entmedia/entmedia032206pkg.cfm>; accessed Aug 22,2008

1. Development of short audiovisual films or “CD spots” in addition to 30-60 second radio and TV spots. The radio and TV spots require substantial budgets for achieving threshold reach and frequency. These may be ineffective given the limited reach of mass media in rural UP. Therefore slightly longer “CD spots” (3-7 minutes) are recommended. These can be circulated, downloaded, used as discussion starters in group meetings, used in cinema halls during breaks, used during local events, run at govt and private hospitals and clinics etc.
2. The use of SMS and text messaging. The situational analysis visits to rural PHCs in Hardoi and Sitapur indicate that most ASHAs have mobiles. A growing number of rural households have mobile phones too. There are an estimated 25 million mobile phone users in UP. A “MAA” campaign (Mobile Advertising and Action to save maternal and newborn lives” can utilize a format like the AVAHAN SMS AIDS campaign described above. A helpline is proposed for ASHAs so that they can avail of expert guidance in case they encounter any problems.
3. The use of SMS and message texting can also have local uses. For example, sending an SMS to VHSC members to remind them about the date, time and venue for the VHND and telling them about the special events of the day. Texting the ANM, MPW, LHV and AWW about preparations of the VHND. Using SMS for monitoring of the VHND, Providing a helpline number for monitoring of the VHND

#### Maximizing media visibility & impact:

NRHM has multiple programs that need implementation concurrently. However, concurrent implementation of BCC campaigns not only overloads the service provider but also deters focussed counselling. Through mass media too, the beneficiary is targeted with multiple health messages which lead to low retention and an even lower level of assimilation of messages.

Figure 4.12 Campaign Strategy (Every year for 3 years)



The keystone of this BCC strategy is ensuring convergence of communication across all channels of communication and service delivery. Therefore 5 core campaign areas have been selected for mass media campaigns which will be run at fixed times every year. All activities including interpersonal communication, community based activities will be coordinated and focussed accordingly. Detailed month wise -topic wise descriptions of topics for ASHA home visits and Group meetings are provided in Annexure 7 & 8 to converge with the mass media campaign strategy.

---

1. A total of 5 behaviour change campaigns targeted at the beneficiaries

- a. Maternal & Neo Natal Health & Nutrition
- b. Family Planning
- c. Adolescent Health & Nutrition
- d. Child Health & Nutrition
- e. Hygiene & Sanitation

2. Motivational Service provider focussed campaign for ANMs, MPWs and Medical officers

3. Gender focussed campaigns focussed on families and communities

The service provider and gender focussed campaigns will be tied in with the main campaign theme i.e. maternal health or family planning or child health or TB etc.

These mass media campaigns will be supported by the IPC at the household level and the village level and the community based activities which will cater to a larger cluster of need specific behaviours.

The mass campaign strategy includes a focus on local media and events in addition to inputs from electronic media. A 12-month mass media strategy is presented below (Table 4.13). The mass campaign strategy provides the following details by month - campaign topic, behaviours to be promoted during that month; use of electronic media (TV/CD/radio), local events for the month (felicitation, panel discussion, poster competitions etc.) and use of print media (posters, leaflets, newsletter etc.). The different campaign themes are highlighted in with the use of colour codes. The mass media activity will peak during the designated months for the campaigns and will continue as reminder activity during the rest of the year. The final scheduling of the mass media activity will be dependent upon the detailed media plan developed by the professional agencies for project implementation.

### **Guidelines for Development of Creatives:**

1. The concept of spiritual merit "punya" for providers and community if maternal, newborn and infant lives are to be saved
2. Use Satisfied users as role models
3. Promote discussion at the household and community levels.
4. Consistently repeat priority behaviours.
5. Address barriers to behaviour change and how to overcome them. For example, mass media will model how a Village Health and Sanitation Committee organizes transport for health emergencies.
6. Promote gender equity and male involvement.
7. Project an ethos that is distinctly Indian. Use socio-cultural concepts of "duty", "respect", "punya". It will focus on the concept of "compassion" in the health provider campaign etc.

**Table 4.13 Mass Media Campaigns**

Month	Campaign	Topic	Behaviours	TV / CD Spots	Radio Spots	Local Events <sup>32</sup>	Print Material
Col 1	Col 2	Col 3	Col 4	Col 5	Col 6	Col 7	Col 8
Month 1	Maternal & Newborn Nutrition / Health	Antenatal Care	<ul style="list-style-type: none"> <li>▪ Early registration &lt; 12 wks</li> <li>▪ 3 ANC check ups</li> </ul>	<ul style="list-style-type: none"> <li>▪ ANC (early registration)</li> <li>▪ ANC 3 check ups/ Age at marriage</li> <li>▪ VHND</li> <li>▪ Role of ASHA</li> </ul>	<ul style="list-style-type: none"> <li>▪ ANC (early registration)</li> <li>▪ ANC 3 check ups</li> <li>▪ Age at marriage</li> </ul>	<ul style="list-style-type: none"> <li>▪ VHND Report Card</li> <li>▪ Felicitation of women who have undergone early registration 3 ANC's etc.</li> </ul>	<ul style="list-style-type: none"> <li>▪ ASHA newsletter</li> <li>▪ Posters with behaviours listed in column 4</li> </ul>
Month 2		Anaemia	<ul style="list-style-type: none"> <li>▪ Eat 1-2 additional snacks a day</li> <li>▪ Eat an iron rich and Vitamin C rich food daily</li> <li>▪ Take 100 IFA tablets during pregnancy or as suggested by provider</li> </ul>	<ul style="list-style-type: none"> <li>▪ Diet (1-2 additional snacks)</li> <li>▪ Age at marriage</li> <li>▪ VHND</li> <li>▪ Role of AWW</li> </ul>	<ul style="list-style-type: none"> <li>▪ Diet (1-2 additional snacks)</li> <li>▪ Age at marriage</li> <li>▪ VHND</li> <li>▪ Role of ASHA</li> </ul>	<ul style="list-style-type: none"> <li>▪ VHND Report Card</li> <li>▪ Recipe comp</li> <li>▪ Rapid quiz</li> </ul>	<ul style="list-style-type: none"> <li>▪ ASHA newsletter</li> <li>▪ Posters with behaviours listed in column 4</li> </ul>
Month 3		Danger signs in pregnancy & Birth preparedness	<ul style="list-style-type: none"> <li>▪ Referral for danger signs</li> <li>▪ Transport &amp; emergency arrangements</li> </ul>	<ul style="list-style-type: none"> <li>▪ JSY benefits</li> <li>▪ Institutional Deliveries &amp; 24 hr stay</li> <li>▪ Birth Preparedness</li> <li>▪ Family &amp; VHSC responsibility</li> </ul>	<ul style="list-style-type: none"> <li>▪ JSY</li> </ul>	<ul style="list-style-type: none"> <li>▪ VHND Report Card</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>
Month 4		Essential Newborn care	<ul style="list-style-type: none"> <li>▪ Colostrum</li> <li>▪ Exclusive Breastfeeding within 1 hour of birth</li> <li>▪ Referral for danger signs in newborn / mother</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provider Campaign (motivation of ANM)</li> <li>▪ Weighing new born</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provider Campaign</li> <li>▪ Radio spot on weighing new born;</li> <li>▪ Giving colostrum;</li> </ul>	<ul style="list-style-type: none"> <li>▪ VHND Report Card</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>
Month 5,6,7	Family Planning	NSV & Female Sterilization	<ul style="list-style-type: none"> <li>▪ Adopt NSV</li> <li>▪ Adopt Female Sterilization</li> <li>▪ Address myths on OCPs, IUDs, Condoms, EC, SDM, Cycle Beads</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provider campaign</li> <li>▪ Satisfied User</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provider campaign</li> <li>▪ Satisfied User</li> </ul>	<ul style="list-style-type: none"> <li>▪ Felicitation of providers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>

<sup>32</sup> Options for different local events will be provided as part of guidelines (Chapter 11)

**Table 4.13 Mass Campaigns (continued)**

Month	Campaign	Topic	Behaviours	TV / CD Spots	Radio Spots	Local Events <sup>33</sup>	Print Material
Col 1	Col 2	Col 3	Col 4	Col 5	Col 6	Col 7	Col 8
<b>Month 8</b>	<b>Adolescent Health</b>	<b>Age at marriage &amp; Health of Adolescent Girls</b>	<ul style="list-style-type: none"> <li>▪ Age at marriage</li> <li>▪ IFA tablets</li> </ul>	<ul style="list-style-type: none"> <li>▪ Age at marriage</li> <li>▪ Nutrition for adolescent girls</li> <li>▪ Spots on SACH</li> </ul>	<ul style="list-style-type: none"> <li>▪ Age at marriage</li> <li>▪ Nutrition for adolescent girls</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mela for married and unmarried adolescents</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>
<b>Month 9, 10</b>	<b>Child Immunization</b>	<b>Routine Immunization</b>	<ul style="list-style-type: none"> <li>▪ 5 contacts per year per infant</li> </ul>	<ul style="list-style-type: none"> <li>▪ VHND</li> <li>▪ Colour coded 5 contact strategy</li> <li>▪ Bal Chetak</li> </ul>	<ul style="list-style-type: none"> <li>▪ VHND</li> <li>▪ Colour coded 5 contact strategy</li> <li>▪ Bal Chetak</li> </ul>	<ul style="list-style-type: none"> <li>▪ Felicitation of child volunteers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>
<b>Month 11</b>	<b>Child Immunization</b>	<b>Pulse Polio</b>	<ul style="list-style-type: none"> <li>▪ Required no. of drops per child</li> </ul>	<ul style="list-style-type: none"> <li>▪ Bal Chetak</li> </ul>	<ul style="list-style-type: none"> <li>▪ Bal Chetak</li> </ul>	<ul style="list-style-type: none"> <li>▪ Poster competition for children</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>
<b>Month 12</b>	<b>Water and Sanitation</b>	<b>Water and Sanitation</b>	<ul style="list-style-type: none"> <li>▪ Use dipper</li> <li>▪ Wash hands with soap after defecation</li> <li>▪ Wash hands with soap</li> </ul>	<ul style="list-style-type: none"> <li>▪ Hand washing</li> <li>▪ With soap</li> </ul>	<ul style="list-style-type: none"> <li>▪ Hand washing</li> <li>▪ With soap</li> </ul>	<ul style="list-style-type: none"> <li>▪ Event for children: well baby competition</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>
<b>Week of Feb 24th</b>	<b>One-week TB Campaign</b>	<b>TB</b>	<ul style="list-style-type: none"> <li>▪ Early detection</li> <li>▪ Complete Treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Symptoms of TB</li> <li>▪ DOTS</li> </ul>	<ul style="list-style-type: none"> <li>▪ Symptoms of TB</li> <li>▪ DOTS</li> </ul>	<ul style="list-style-type: none"> <li>▪ District and State level events</li> <li>▪ School based events</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>
<b>Week of June 5th</b>	<b>One-week Vector Borne Campaign</b>	<b>Malaria / Dengue / Filaria</b>	<ul style="list-style-type: none"> <li>▪ Cover stagnant water</li> <li>▪ Empty water containers</li> <li>▪ Alert for outbreaks</li> </ul>	<ul style="list-style-type: none"> <li>▪ Cover stagnant water</li> <li>▪ Empty water containers</li> <li>▪ Alert for outbreaks</li> </ul>	<ul style="list-style-type: none"> <li>▪ Cover stagnant water</li> <li>▪ Empty water containers</li> <li>▪ Alert for outbreaks</li> </ul>	<ul style="list-style-type: none"> <li>▪ Shram daan to clean drains, cover stagnant water</li> </ul>	<ul style="list-style-type: none"> <li>▪ Posters with behaviours listed in column 4</li> </ul>

<sup>33</sup> Options for different local events will be provided as part of guidelines (Chapter 11)

## D. Integration of BCC Efforts with State Level NGOs and Development Partners

Uttar Pradesh has several national level NGOs and development partners working in the field of health. Development partners have an important role in the context of scale up, monitoring, and capacity building. Mahila Samkhaya is another organization that can play a major role through community mobilization and demand of health rights.

It is very important that development partners also focus on the priority behaviours outlined in this strategy document in their areas of work. The principle of using “priority behaviours” should also apply to the development of AV materials. Consistency in message concepts and images will further strengthen the effectiveness of BCC inputs. Almost all these organizations are involved in BCC efforts and programs. The successful implementation of the proposed BCC strategy of the state is dependent on how well coordinated the BCC efforts are across and within agencies. Otherwise the concept of synchronized campaigns cannot be implemented. Instead there will be a situation of mass confusion with too many messages and too little behavioural change. Therefore coordination with the SPMU and establishment of a monthly BCC review meeting is essential.

### Responsibilities of State Level NGOs and Development Partners

- Advocacy including Media Advocacy
- BCC Capacity Building and Supportive Supervision of ASHAs for Home Visits and Group Meetings
- Supervision of VHND and Capacity Building of the Health and Sanitation Committees
- Establishing an SMS based Campaign for Male Involvement in Maternal Health and Family Planning & a Helpline for ASHA
- BCC Monitoring

### Coordination & Convergence of all NGO & DP activity with NRHM BCC strategy for effective BCC

NGOs, CBOs, Development Partners and other private practitioners should all follow the broad NRHM BCC strategy in Uttar Pradesh, especially its focus on priority behaviours. Development partners can use the guidelines developed in the document for the preparation of BCC materials and implementation of BCC programs. BCC inputs at all levels should highlight core campaign themes and priority behaviours.

Coordinated efforts will lead to a more efficient and effective use of resources. Uncoordinated work often leads production of BCC materials on the same topic by different development partners and agencies. Currently there is no overarching BCC strategy that guides different stakeholders in a planned, systematic manner.

Resources can be aligned towards a common goal if various stakeholders broadly endorse the overall BCC strategy and integrate and implement it their ongoing work. A monthly or quarterly review mechanism should be put into place to institutionalize the coordination between Development Partners. Specific roles and tasks should be assigned to DPs to assist the NRHM.

---

The following roles are proposed for the development partners and state level NGOs:

- **Political & Media Advocacy:** media advocacy, political advocacy through pradhan exposure visits, working with faith based organizations etc. NGOs and development partners can undertake the advocacy role for BCC. This role entails focussing on behaviour focussed efforts so that the gatekeepers are given a clear brief on which behaviours to promote.
- **BCC Capacity Building and Supportive Supervision of ASHAs for Home Visits and Group Meetings:** This is a crucial step and development partners working at the district level can play an immense role in building BCC capacity of the ASHA.
- **Supervision of VHND and Capacity Building of the Health and Sanitation Committees:** An operational role of the village health and sanitation has been developed in this strategy document. NGO or development partners can undertake the responsibility of community mobilization and capacity building of health and sanitation committees.
- **Establishing an SMS based Campaign for Male Involvement in Maternal Health and Family Planning & a Helpline for ASHA:** The Heroes Project of AVAHAN has implemented an SMS based campaign for youth in the context of HIV (details in Chapter on BCC Innovations). A telecom provider can be involved in establishing the SMS campaign for maternal health and family planning in Uttar Pradesh. It can also take the responsibility of establishing an ASHA helpline.
- **BCC Monitoring:** The strategy document outlines a BCC monitoring strategy. The State will require technical assistance to establish a BCC monitoring system.

## BCC Innovations

There is scope to introduce innovative BCC strategies within the 3 year strategic plan period. Several innovative BCC strategies are proposed in the following categories:

- Alternative Media and Materials Innovations
- Community based BCC strategies
- BCC programs.

It is suggested that the innovations can be piloted in 10-15 districts and then expanded to the rest of the state.

### 1. Use of short audio visual films or “CD Spots” to Increase Media Reach

Power shortage in Uttar Pradesh is amongst the worse in the country. Interviews with stakeholders at the PHC and sub centre levels indicate that power cuts can occur for 12-14 hours a day. The challenge in such a scenario lies in using the newly emerging media in addition to TV and radio to extend media reach.

The CD spot/short film approach has the potential of overcoming the shortcomings of TV and radio time in terms of reach. In addition, it enables a sharper and more defined audience focus and will be more cost effective compared to prime time TV costs.

This strategy proposes the use of CD spots at various sites - PHCs, clinics, VHNDs, group meetings, etc. to ensure that audio visual inputs are provided to a larger number of people. However the effectiveness of this strategy will depend on logistics planning in terms of distribution and use.



---

## 2. An IPC Tool for Home Visits

A simple visual BCC checklist to be used during home visits by ASHAs. This BCC tool will enable the ASHA to:

- Assess the BCC needs of the household
- Diagnose the behaviours that require change & behaviours that need to be maintained and assist in the provision of behaviour specific messages
- Assess the reasons for not adopting a particular behaviour & provide BCC addressing the reasons for non-use

The BCC checklist has been developed by IHMP and has been used at their rural and urban health sites in Maharashtra for more than 10 years. Recently the checklist has been adapted for MNH for the Sure Start programme in Maharashtra, which covers about a 10-12 lakh slum population.

## 3. Use of SMS and Cell Phones for Maternal Health

The potential of alternative media to increase the reach of media to rural audiences is high. The cell phone/text messaging technology will be used for:

- A quiz contest for men on maternal health
- A helpline for ASHAs
- Interacting with private practitioners
- Tracking ANMs and VHNDs

## 4. Low Cost Cookbook of Iron rich and Vitamin C rich recipes

This cookbook has been developed IHMP for anaemia prevention in married and unmarried adolescent girls. An adaptation of the cookbook is proposed.

## 5. “Shubh Vivah” Kits for Newly Married Couples and “Badhai Kits” for New Borns

BCC inputs are most effective when they are provided closer to the time when behaviours are expected to occur. For example, if newly married couples receive counselling and materials immediately after marriage, there will be a higher likelihood in delaying first conception. A special event for newly married couples is planned at the village during a VHND. Newly married men can be sensitised to the multiple gender roles their young wives have to assume upon marriage.<sup>34</sup> “*Shubh Vivah*” kits will be given to couples.

The kit should include materials on the following issues:

1. Respecting one’s wife, providing her with support and understanding her position as a young, new daughter-in-law.
2. Communication between husband and wife
3. Childbearing and its risks for married adolescents
4. Whom to contact for further information
5. A packet of “*Bindis*” for the woman and a comb or other such gift for the man.
6. Contraceptive choices and options; condoms; information on oral pill and IUDs

---

<sup>34</sup> Kapadia-Kundu N., Khale, M, et al (2007) “Whose Mistake? Gender Roles and Physical Violence among Young Married Women”. Economic and Political Weekly, Nov 3, 2007 pp 71-78

---

Similarly JSY offers an opportunity to counsel a woman who has just delivered. Her family members who accompany her to the health facility can also be counselled. Family counsellors are going to be appointed at a CHC level. A newborn care or “*Badhai*” kit that outlines care of the mother and newborn should be given to the family / woman prior to discharge. Preferably the key contents of the kit should be discussed with the woman and her family members.

The kit should include the following:

1. A baby card that mentions the baby’s weight at birth, immunization schedule, growth card, diet etc.
2. Importance of PNC and PNC schedule
3. A card on essential newborn care. Do’s and don’ts
4. Care of mother and diet.
5. Condoms

#### **6. Home Calendars for Eligible Couples/ Giant Village Level Growth Card/Village Report Card**

The strategy also recommends the use of community based BCC materials that have sustained reach. For example, every eligible couple can be given a calendar on maternal care or care of a child under three years. This calendar can include a section on monitoring and can enable the family to track important dates related to RI.

BCC tools that can facilitate community level visibility and enhance community responsibility are required at the village level. One such tool can be a large growth card that is placed in the Gram Panchayat office.

The concept of a village health card can be promoted through regular tracking of VHND.

#### **7. Community Notice Boards and colour coding of ASHA’s Home**

Community notice boards are useful as they provide visibility at the village level. They can also be used to promote village events such as Khushali Diwas, Group meetings, RI sessions, Radio, TV programs, TV serials (health related) etc. There can be about 3-4 notice boards per village and they can be placed in prominent areas such as Gram Panchayat office, ASHA home, school etc.

Painting the ASHA’s house and listing the main services she provides will help create an identity for the ASHA.

#### **8. Community based BCC Strategies: The Bal Chetak strategy for RI (Routine Immunization)**

There is scope within NRHM for each state to undertake need specific innovations. The BCC strategy document proposes two innovative community based BCC strategies that will take the state forward in improving the health of its women and children. The first innovation is the use of child-to-family and child-to-community approaches to implement a sustained behaviour change campaign to increase RI coverage.

The Bal Chetak strategy can also be used to promote hygiene and sanitation. Specifically the following hygiene behaviours: (1) hand washing with soap after defecation, (2) hand washing with soap after cleaning child’s stools and (3) hand washing with soap before feeding a child under three years. Studies have shown that location of soap within the household is a key determinant of hand washing with soap after defecation. The campaign should focus on ensuring that soap is placed within a convenient location in the household to facilitate behavioural change.

---

## **9. Colour coding for RI campaign**

The ancient Indian theory of communication “Sadharanikaran” or “simplification without dilution” is most relevant to the RI context. BCC initiatives in RI pose a challenge because of the number of vaccines, varying doses per vaccine and differing time intervals between doses. Add to that, the number of booster doses and the list is quite formidable. Often the main behavioural message gets lost in a large clutter of information.

Sadharanikaran enables the design of simple, easy to comprehend, persuasive inputs to enable infants to be immunized. The BCC strategy proposed for RI will simplify the RI campaign through a colour coding mechanism that focuses on “5 contacts per year”. The colour coding will facilitate comprehension and recall as most people are familiar with basic colours while they may not recognize terms such as “DPT” or “booster” etc. The Bal Chetak strategy planned for providing persuasive inputs for RI will also ensure a level of simplification as child communicators

## **10. Innovative BCC Programs : Anaemia Prevention in Adolescent Girls through Nutrition Education**

India has the highest rates of iron deficiency anaemia in the world. The UP State Action Plan proposes to provide children 6-10 years with three months of IFA supplementation. It is suggested that this programme should be extended to girls 10-19 years too and it should be supplemented with nutrition education promoting iron rich and Vitamin C foods. A community based randomised field trial in Maharashtra has shown that anaemia and under nutrition in adolescent girls (10-18 years) can be prevented if sustained dietary change follows an initial 3 month iron supplementation effort (Kapadia-Kundu et al, 2006).

## **11. SMS Campaign and Promoting Use of Temporary Methods of Contraception through Private Medical Practitioners**

There are 25,000 registered homeopaths and 50,000 registered ayurveda and unani practitioners in the state. Their services could be used for the provision of counselling and contraceptive services to young married couples.

## **12. Saas Bahu Sammelans**

Indian households have hierarchies that determine the communication patterns between mothers-in-law and their young daughters-in-law. Informal rules of communication and prescribed gender roles ensure that the mother-in-law’s approval (either tacit or expressed) is essential for many contraceptive, maternal and new born care behaviours. Sadharanikaran enables us to recognize and address the unequal, asymmetrical patterns of communication at the household and community levels in Uttar Pradesh.

The purpose of the “Saas Bahu” Sammelans is to generate lateral communication between “Saas-Bahu” duos/pairs. The objective is to elicit “support” and “compassion” towards daughters-in-law in households where they are denied both due to a strict adherence to gender role expectations. The purpose is to also show positive role models of mothers-in-law who do extend support and compassion to their young daughters-in-law. The behavioural themes for the Saas Bahu Sammelans are institutional delivery and delay in first conception.

## **13. Swasthya melas**

The Swasthya Melas strategy is one that is already in place. However the innovation that is being proposed is that different stalls are set up to complement the health service component. These stalls include the “Nutrition Stall” “RI stall” “Counselling for Newly Marrieds” etc.

An opportunity to directly interact with young married couples is feasible. Counsellors should be available at these Melas and planned promotional inputs for the Mela should be in place to ensure that young married couples attend the Mela.

## NRHM campaign wise suggested strategies at a glance:

### Campaign 1: BCC Interventions for Maternal and Newborn Health

#### ▪ IPC And Community Level

- Home Visits – 3 for ANC and 2 for PNC
- VHND / Khushali Diwas
- Group Meetings by ASHA/ANM (list in Annexure 7 and 8)
- Saas Bahu Samellan
- Shubh Vivah kit for newly married couples
- Village Health and Sanitation Committee to monitor health needs and service coverage of food insecure HHs; make linkages with Anganwadi; to mobilize community resources to assist food insecure households.
- Swasthya Melas on a pilot basis
- Folk performances

#### ▪ Facility Level

- Family Counsellor
- Badhai Kit for family and newborn
- CD spots/short films
- Wall paintings with details of JSY and whom to contact if services are not available

#### ▪ Mass Media

- The BCC mass media interventions include TV, radio and CD spots. The following TV/CD spots are recommended:
  - On early registration (< 12 weeks); where to register; whom to meet.
  - Three ANC check ups; focus on the number “three” – provide details of when, where etc.
  - Motivating pradhans and village health and sanitation members to “save maternal and new born lives” by ensuring early registration. Focus on the concept of “punya” (spiritual merit) as a motivation for ensuring actions to prevent maternal and new born deaths.
  - Show male responsibility for early registration and 3 ANC check ups.
  - Show VHND “Khushali Diwas” as a day that maternal health services including ANC registration and check up are available monthly at a village level.
  - Show ANM doing early registration and 3 ANC

### Campaign 2: BCC Interventions Institutional Delivery & 24 hrs Stay

#### ▪ IPC and Community Level

- Promotion of JSY through IPC, VHND and group meetings
- Wall painting with ASHA services and details of JSY at ASHA home.
- Home visits by ASHA to promote birth planning
- One group meeting on birth planning
- Community level interventions through VHSC provision of transport for woman due for delivery.
- Swasthya Mela on a pilot basis
- Folk Performances

#### ▪ Facility Level

- Wall painting on JSY.
- Health providers at facilities to promote institutional deliveries.
- Badhai kit to be given after 24 hour hospital stay.
- Complaint number if family is asked to leave facility by health providers prior to 24 hours.

#### ▪ Mass Media

- The following TV/CD Spots are suggested:
  - JSY (already available); for new CD/TV spot add the need to stay for 24 hours in the facility; ensure immediate breastfeeding at the facility; and provision of BCG to the newborn etc.
  - Role of the VHSC in arranging transport. Spot should list various options of transport. Focus on “spiritual merit” for committee members for saving maternal and newborn lives.
  - CD Spot on emergency transport.

#### Development of AV Materials/BCC Tools for IPC and Community Level BCC

- IPC home visit tool - birth planning, JSY and hospital stay of 24 hours; essential behaviours for safe home delivery (*refer modified BCC Log Frame 2 for details*); essential newborn care
- A “Badhai” kit for mother on discharge from the facility. *Refer note for details of the Badhai kit.*
- Posters on JSY and need for 24 hours hospital stay; Posters on organizing emergency transport; Posters on “spiritual merit” for village health and sanitation committee members; “pradhan” etc.

### **Campaign 3: Newborn Care**

#### **▪ IPC And Community Level**

- Two PNC home visits by ASHA – the first within 48 hours of birth; and the second from 3-7 days of birth (proposed home visit IPC tool will enable ASHA to identify danger signs in mother and newborn and ensure referral).
- Group meeting on newborn care.
- Linkages with anganwadi worker to weigh the newborn within 24 hours in case of home deliveries.

#### **Development of AV Materials/BCC Tools:**

- IPC tool for new born care.
- Immediate Breastfeeding message on match boxes; linkages with manufacturers of baby products to feature messages on immediate and exclusive breastfeeding.
- Calendar on maternal and newborn care with a checklist of services required to be given during ANC registration or ASHA home visit. Used as a tool of household level monitoring.
- Posters at CHC on the following
  - No bath for a week
  - No prelacteal feeds (mother's milk has enough water for baby)
  - Skin to skin care

(The newborn care project in Shivgarh has done extensive work on developing socio-culturally relevant and behaviour specific messages in the context of rural Uttar Pradesh. It is recommended that this work be referred to when BCC materials are being developed for newborn care.)

#### **▪ Health Facility**

- BCC and ensuring essential newborn care; care of low birth weight baby to be provided by hospital nurse and/or family counsellor at health facility
- Badhai kit for newborn and family

#### **▪ Mass Media**

- CD/TV/Radio Spots:
  - Immediate breastfeeding; no prelacteal feeds (mother's milk has enough water for baby).
  - Skin to skin care.
  - No bath for a week.
  - Wrapping baby in soft cotton cloth etc.

### **Campaign 4: Family Planning**

#### **▪ IPC And Community Level**

- Focus on married adolescents with the aim of delaying first conception
- Six home visits a year by ASHA to married adolescent.
- Felicitation of couples at VHND who have delayed first birth by more than one year.
- Local Events at the village level to promote couple communication.
- Two VHNDs a year (to coincide with the marriage season) to focus on needs of newly married couples.
- "Shubh Vivah" kit for newly married couples;
- Addressing gender and son preference using "spiritual merit" approach. Involving men, village elders.
- Addressing myths and misconceptions about IUDs, oral pills, NSV, contraceptive mix etc.
- Quarterly home visits by MPW to newly married men.
- Local event on delaying first conception.

#### **▪ Health Facility**

- A motivational campaign endorsing the "spiritual merit" approach for ANM. MPW and other health providers.
- Since family planning services are not available at the village level, planning a public-private partnership with local RMPs. Building capacity of RMPs to provide temporary contraceptive services. An SMS campaign can be used.
- Using institutional delivery as an opportunity to counsel woman and her family members on spacing/terminal methods of family planning.
- SMS campaign for male involvement in family planning

#### **▪ Mass Media**

- TV/Radio/CD Spots
  - Delay first conception (campaign to run during wedding season).
  - Promote IUD.
  - NSV and Female Sterilization.

### **Campaign 5: Nutrition of Adolescents and Women (adolescent girls, married women, pregnant women)**

#### **▪ IPC And Community Level**

- Home visits to married adolescents, pregnant women and eligible couples.
- Use of cookbook to promote dietary change.
- Training frontline workers in focussed, feasible and need based nutrition education.
- Linkages with anganwadi for households that do not have food security.
- Group meetings twice a year for married women.
- For food secure HHs:
  - Promote a daily evening snack for women;
  - Promote two additional snacks daily for pregnant women;
  - Home visits and follow up by ASHA;
  - Recipe competitions during nutrition week.

#### **▪ Health Facility / School Level**

- An in-school anaemia prevention programme for girls 9-14 years. It includes 3-month IFA supplementation and dietary change.
- Child-to family school intervention on nutrition.

### **Campaign 6: Child Health**

#### **▪ IPC And Community Level**

- Home visits for promotion of nutrition in children under three years
- Group meetings
- Community Growth Card
- Local events
- VHND
- Khusali Diwas
- Identify households with low food security and make linkages with the anganwadi.
- Village health and sanitation committee to monitor households with low food security.

#### **▪ Mass Media**

- TV/CD spots on complementary feeding at six months; focus on frequency of feeds.
- Child-to-community approaches to promote hygiene behaviours.
- TV/CD spots on hygiene behaviours.
- TV/CD/Radio spots on discrimination against the girl child (< 3 yrs); focus on care of second surviving girl.

### **Campaign 7: Routine Immunization**

#### **▪ IPC And Community Level**

- VHND
- Date/time for RI sessions prominently displayed on village notice board and other prominent places in the village.
- Involve school children in tracking infants in village (about 30-40) for RI coverage; motivating mothers to bring children for RI session 5 to 6 school children (12-14 years) to monitor immunization coverage of infants; motivate mothers to bring their children for RI session; take on immunization coverage as a "community project" for the children.
- ANM to conduct RI along with Pulse Polio.
- Distribute ORS packets during PP house to house visits.
- Establish a system through which villagers can register a complaint if VHND is not held.
- Special outreach sessions in urban slums.
- Reminder postcards to be sent to JSY beneficiaries.
- Non JSY beneficiaries to get BCC on RI through home visits.

#### **▪ Mass Media**

- The TV/Radio/CD spots on immunization should focus on number of yearly contacts. Use the colour coded strategy for RI
- CD spot on reminder post cards

### **Campaign 8: Revised National Tuberculosis Control Programme**

#### **The interventions proposed are:**

- A well planned one week TB prevention and control campaign.
- Additional inputs in the high priority districts.
- Preparation of BCC materials according to guidelines provided in this strategy document.
- Focus on urban slums.
- TV/Radio/CD spots to focus on specific behaviours.
- Broadcast special programme to school children during TB week.
- Strengthen linkages with medical colleges.

### **Campaign 9: Vector Borne Diseases**

#### **▪ IPC And Community Level**

- Preparation of village and district level plans for prevention and management of outbreaks.
- Building capacity of the village health and sanitation committee to manage outbreaks.
- Developing BCC plans for running flash campaigns in case of sudden outbreaks. This would include outbreak specific radio, TV, press and print materials with specific details on actions to be undertaken.
- Child to community approaches to ensure that water containers are emptied once a week.
- Child to community action on prevention of breeding sites.
- Posters on how to alter authorities and the village health and sanitation committee in case of a outbreak.

#### **▪ Mass Media**

- Localized campaigns on prevention and management of outbreaks in endemic areas

### **Campaign 10: National Programme for Prevention of Blindness**

#### **▪ The proposed interventions and strategies are:**

- Selection and up gradation of NGOS.
- Running a planned campaign during blindness prevention week.
- School eye screening to be done during school health weeks.
- During eye-screening week give school children pamphlets on cataract surgery that they can distribute to households with elderly persons.
- TV and radio spots with details of eye screening facilities and cataract surgery facilities.

### **Urban Health**

About 20 percent of UP's population resides in urban areas and its slum population is estimated at 10 million<sup>35</sup>. Rapid urbanization is a trend that will continue. Unfortunately the health needs of the urban poor have largely been invisible in the context of public health policies and programs in India. A well defined primary health care infrastructure is not in place in most cities and towns. The new National Urban Health Mission hopes to address most of these gaps in meeting the health needs of the urban poor. The challenge for urban primary health care is establishing a health delivery system and a BCC system that will cater to the health needs of the urban poor.

The focus of the NRHM BCC strategy document is on convergence. Therefore the overarching BCC strategy that is recommended for NRHM should be applied to urban areas too, with appropriate adaptations and modifications. The key BCC gaps within the urban sector are the lack of coordinated BCC inputs and plans and absence of planned community level BCC activities. The overall BCC strategy for the urban context would remain more or less similar to the BCC strategies proposed in this document.

However, special urban considerations include:

1. Identification and listing all segments of the urban poor in cities and small towns. These include unrecognized slums, temporary settlements, pavement dwellers and street children.
2. Planning BCC services to reach all vulnerable groups within the urban spectrum.
3. Selection, training and role specification of USHAs. The BCC role of the USHA will be similar to the role outlined for ASHAs.

<sup>35</sup> Govet of UP (2008) "NRHM: State Action Plan 2008-2009"

- 
4. The use of alternate media such as SMS campaigns has promise in the urban sector. However, these media should be used to bolster community based campaigns and not as independent endeavours.
  5. BCC on prevention of malnutrition, anaemia, water borne diseases, vector borne diseases etc. should be accorded a priority in the urban context.
  6. BCC efforts on TB and HIV should receive a priority focus within the urban sector.
  7. Access to services in the urban context, is not a major barrier. Focussed BCC inputs that ensure linkages with appropriate health service providers and facilities are essential.
  8. The community mobilization component is weak in urban areas. Decentralized PRI structures such as the Gram Panchayat are not existent. Priority should be accorded to establishing Health and Development Committees in urban slum communities.
  9. At an institutional level, the responsibility of BCC will have to be assigned and leadership positions for BCC will have to be created within urban local bodies.

**To summarize the overall BCC strategy will include the following:**

- There will be uniformity in behaviours promoted across different channels and media. All persuasive inputs will be linked to action i.e. every BCC interaction whether it is electronic mass media, interpersonal communication, group meetings etc. will refer to the same set of behaviours agreed upon (refer Chapter 3).
- The mass media strategy will include 4-5 special mass media campaigns on behaviour change, health providers and gender. Local media will be used to provide details of time, place and date of services.
- Need specific BCC at the household level will be provided through home visits by ASHA.
- The BCC strategy will also promote couple, household and community level communication.



## Immediate Short Term BCC Strategic Plan

A Short-term BCC strategy (one-year) has been prepared to meet the State's requirement of immediate implementation of a planned BCC programme under NRHM. The focus of this one-year plan is to enable operationalization of at least the IPC and community level BCC activities and mass media campaigns. It will be feasible to implement these campaigns in the short term as existing TV and radio spots as well as print materials (eg flipbook for ASHAs). This period of one year will also serve as a preparatory phase for the development of the mass media campaigns and materials and for piloting a number of BCC innovations.

In addition, the one-year BCC strategy will concentrate on the following:

- (1) Establishment of the Village Health and Nutrition Day (VHND). VHND assumes vital significance in Uttar Pradesh as it presents an opportunity for the provision of regular outreach services at the village level.
- (2) Establishing community based BCC approaches such as home visits by ASHA and groups meeting by ASHA and ANM.
- (3) Mass campaigns that address the main barriers to health and health seeking behaviours. These campaigns will include sub-campaigns on provider motivation and gender.

To facilitate implementation of the BCC strategy, a detailed set of Gantt charts with timelines for the first year are enclosed in Annexure 11.

### A. Community Level BCC

#### ▪ Monthly Village Health and Nutrition Day (VHND)

A monthly VHND day has been proposed where there is a convergence of services available at the village level and the ANM, MPW, Anganwadi worker, village health and sanitation committee, school children etc. all come together to ensure that basic services and essential BCC are provided at the village level at least once a month.

The topics, behavioural focus and strategies for the group meetings to be conducted by the ANM during the VHND are provided in Annexure 8.

The first year of the BCC strategy will focus on establishing the VHND at the village level. The strategy includes placing an annual VHND schedule on the village notice board and providing a helpline number where complaints can be registered if the VHND is not held as planned.

#### ▪ Home Visits by ASHA

One of the most important elements of the NRHM has been the policy to introduce an ASHA at the village level for every 1000 population. Most of the policy makers interviewed requested that a more specific BCC role for the ASHA be defined. A simple IPC tool to be used by ASHAs during home visits is being proposed. The community based BCC materials to be developed in the first year include:

- 
- IPC tool for ASHA home visit
  - Low cost cookbook “Prevent Anaemia Now!” of iron and Vitamin C rich recipes
  - MNH Kit to be given to mother after delivery
  - Kit for newly married couples
  - Monitoring tool for the ASHA Home Visit

Interactions with ASHAs from Sitapur and Hardoi districts during the preparation of this strategy document indicated that there is no fixed strategy for group meetings currently in place. Some ASHAs conduct meetings, some don’t. Some cover all the topics provided in their ASHA flipbook in one group meeting, others choose any topic of their choice.

It is now proposed that there will be a defined monthly work plan for group meetings to be conducted by ASHAs. This 12 month plan has been outlined in Annexure 7. The group meetings are synchronized with the core campaign themes. The key behaviours to be repeated and reinforced during the meeting have also been listed (refer Annexure 5).

A few policy decisions that will be required for the above strategy to be implemented. They are:

1. Service provision at the village level: The ANM should do abdominal examination and check the blood pressure of pregnant women at the village level. It is unreasonable to expect a pregnant woman to go to a sub-centre just for these two ANC services.
2. BCG must be given to all newborns at the facility itself.
3. UP has limited BCC human resources. Therefore block BCC officers are required to oversee and provide strategic inputs to BCC at the block level.
4. Approval of the home visit schedule for the ASHA.
5. Coordination with GOI to provide existing software and working with local cable network

## **B. Mass Media Campaigns**

### **▪ Utilizing Existing Software:**

In order to effect convergence in communication and due to the urgent need to operationalize mass media activity, it is proposed to utilize the existing software available with the Government of India for NRHM and extend the reach of the GOI mass media plan by utilizing local Television and Radio channels. The GOI software includes spots on JSY, early marriage, diarrhoea management, birth spacing. In addition to the GOI software, existing software within the State was also reviewed for suitability. Two campaigns ie the “SUVIDHA” campaign and the Female Sterilization Campaign developed by SIFPSA were found appropriate for re-airing. These campaigns should be used to support the special camp strategies for promotion of Female Sterilization and IUDs.

The SIFPSA Radio Drama series “*Sunehre Sapne Sanwaarti Rahein*” and the UNICEF’s TV serial “*Kyunki jeena isi Ka Naam hai*” are very relevant for the NRHM programs. “*Sunehre Sapne Sanwaarti Rahein*” should be utilized by re-airing on All India Radio and other private radio channels. “*Kyunki jeena isi Ka Naam hai*” is currently being aired on Doordarshan’s National Network. As UNICEF is agreeable to provide the episodes of the TV serial to the state for local airing, it is proposed that airing of the serial on cable channels through the Entertainment Tax Departments of the State Government be explored as a public private partnership where the local cable channels can air the programme at a fixed day/time across the state free of cost in return for the programme software.

### ▪ Development & Production of New Campaigns & Materials:

In the meanwhile, it is proposed to operationalise the new campaigns suggested by the BCC strategy in line with the selected core behaviours. The New TV, radio spots and CDs (short films) to be produced in the first year are:

1. TV, radio spots and short films (CD spots) promoting early registration, 3 ANC check ups, diet during pregnancy (eating 3-4 times a day), weighing newborn, hand washing with soap after defecation (focus on soap location), delaying first conception for married adolescents, exclusive & immediate breast feeding.
2. TV, radio spots and short films (CD spots) on VHND
3. TV, radio spots and short films (CD spots) on the “puniya” (spiritual merit) campaign for saving maternal and newborn lives will feature ANMs, MPWs, medical officers, village health and sanitation committees, mothers-in-law, fathers-in-law
4. Gender spots (TV, radio and CD) - maternal nutrition, ANC check ups, early treatment seeking for girl child, etc,
5. TV, CD and radio spots on colour coded RI strategy and Bal Chetak strategy

Gantt charts outlining the first year implementation of the BCC strategy are outlined in Annexure 11 and provide a timeline for implementation. This timeline will enable review and progress of implementation; assist in planning work and assigning tasks. The time-line covers all the national programs and is based on the overarching strategy outlined in the earlier chapter.

## C. Special Health Days:

A calendar of events that includes planned activities for different health days can enable in creating an enabling environment for behavioural change.

**Table: 5.1**

Date	Event	Suggested Activities
Jan 1	Anti-Addiction Day	Press Release/Print advertisement
Jan 30	Anti-Leprosy Day	▪ State Level Functions
Jan 30-Feb 5	Anti Leprosy Week	▪ School awareness drive
Feb. 5	Oral Hygiene day	▪ Dental check-ups for rural adults in selected blocks (public-pvt partnerships); Press release
Feb. 24	Anti - TB day (anti TB week)	▪ State level function felicitating DOTS volunteers; special screening camps in remote areas; TB awareness activities in 50 schools per district
Mar 8	Women’s day	ASHA Sammellan at state and district levels
April 7	WHO day	▪ “Khushali Diwas”
April 10	Safe Motherhood Day	▪ Felicitation of married adolescents who have delayed first conception; press release on dangers of early motherhood
May 12	Florence Nightingale Day	▪ Felicitation of ANM at district and state level functions; felicitation of ANM at sub-centre level function

June 5	Environment Day	▪ State wide tree plantation drive in every village; child to community activity; each child to ensure survival of the sapling for an entire year.
June 10	Prevention & Control of Curable Blindness	▪ School eye check ups; cataract camps; press release; banners
July 11	World Population Day	▪ School competitions; counselling camps for newly married couples in selected blocks in collaboration with colleges of social work
Aug. 1-7	Breastfeeding Week	▪ 2" by 2" card promoting colostrum feeding to be given to every pregnant woman
Aug 23	ASHA Diwas	▪ District Level ASHA Sammellan
Sept. 1-7	Nutrition Week	<ul style="list-style-type: none"> <li>▪ Release cookbook (if ready)</li> <li>▪ Nutrition session and quiz for adolescent girls in schools (can be administered by their school teachers; guidelines can be prepared)</li> <li>▪ Recipe competitions of iron rich and vitamin C rich foods to be organized in selected schools and villages;</li> <li>▪ Felicitation of recipe competition winners at function in 3-4 cities</li> </ul>
Sept 22	Blood Donation Day	▪ Blood donation drives to be organized (one per block)
Oct. 2	Cleanliness Day	▪ Shram daan by children; house to house visits by children on hand washing with soap after defecation
Oct 10	World Mental Health Day	▪ Press Release; Panel Discussion at State Level
Nov. 14	Children's Day	▪ Bal Melas at District Level; speech competition; poster competition; panel discussion etc.
Dec. 1	World AIDS Day	▪ State level function on stigma reduction
Dec 8	SAARC Day of the Girl Child	▪ Felicitate
Dec 31	Anti-Tobacco Day	▪ Press ads

#### D. Media Advocacy:

Media Advocacy is an important component in the BCC strategy that can be operationalized within the short term plan. A plan to engage the media in creating an environment that promotes the provision of good quality health services at the PHC, sub centre and outreach levels, is necessary. The media can play a major role in highlighting issues, problems and successes related to NRHM. The story of an enlightened ASHA can inspire many others; similarly the story of an ideal ANM could do the same. The media can also emphasize the role of male involvement. The local media and press should be engaged on a regular basis.

Through a series of media advocacy workshops, local media professionals can be oriented with the objectives of the NRHM and the programme strategy, impacts & achievements. These workshops would be used for training the media in advocating for Family Planning and Reproductive Health. The workshops would help in emphasizing the role of media in sensitive and accurate reporting.

---

Through a continuing news media relations strategy using a mix of press kits, briefings, fact sheets and site visits, the media would receive regular updates on the program, be provided with data, information and stories of role models and real life heroines and heroes.

### **E. Political Advocacy:**

There is an urgent need to sensitize the elected public representatives on the social value of the different schemes under NRHM. A detailed plan for engaging and enlisting the support of the elected public representatives at the village, block and state level needs to be implemented in the short term political advocacy efforts taking the non-controversial public health schemes pertaining to Maternal & Child Health, Nutrition etc.



## **PART II**

### **Operational Aspects of the NRHM BCC Plan for Uttar Pradesh**





## Long Term Strategic Plan

### State Level BCC Tasks & Responsibilities

#### Long Term (3 Year) BCC Plan

**T**he strategic vision for the State is to develop the capacity for effective BCC implementation. This implies an acute need to develop BCC plans at the district and block levels. Traditionally BCC programs have focussed on the design and development of AV (audio-visual) materials. As a result planning concepts such as service coverage, monitoring outputs and outcomes etc. are lacking in most community level BCC programs. While services such as immunization are able to report the percentage of children covered in an eligible population, BCC activities are reported in actual numbers i.e. number of meetings held. The expected number of people to be reached by BCC activities is not estimated at all. Often BCC inputs are not planned according to behaviours that require change but more “to fill the information gap”.

The long-term BCC plan for the State envisages a continuation and consolidation of the implementation strategy described in Chapter Five. In addition, the long-term strategy aims to build BCC planning capacity at the district, block and village levels. This will include skills in BCC planning, implementation, supervision and monitoring. Another long-term strategic goal for BCC is to develop capacity in the Village Health and Sanitation Committees to ensure service provision at the village level.

The long term objective will be to have district BCC plans ready by 2010 for all 71 districts. This will be feasible only if accurate and reliable information is available at the district level. The existing information system is not systematic or reliable. A review of the routine immunization programme shows that the MIS indicated coverage levels of 114 percent for BCG but independent studies showed a very different scenario<sup>59</sup>.

The Institute of Health Management Pachod (IHMP) had prepared a list of information required to prepare district BCC plan for a district BCC planning project it had undertaken in Maharashtra. This comprehensive list is provided in Annexure 8. The first step towards the development of district and block plans would be get information on health service coverage and health behaviours for each block that will enable the assessment of intra sub-centre and inter-sub centre variations in health service utilization.

#### Decentralized BCC Planning

Capacity for micro planning should also be developed. Ideally, health personnel working at the village and outreach levels should know how many couples there are with 2, 3 and more children, number of newly married couples, number of infants and children under-three in the village. A monthly BCC plan should be developed and implemented by the ASHA, ANM and MPW. The ANM and MPW must ensure that the monthly VHND is held and that women receive ANC examination at the village level etc.

---

A block level BCC plan with PHC and sub-centre wise micro-plans should be developed BCC in accordance to programmatic strategies outlined in NRHM eg VHND, “Bal Poshan month”, NSV camp, school health week etc. There should be role specification at the district level about who will do what, how and when in order to provide uniformity across the PHCs and sub-centres in different blocks.

### **Strengthening Local Capacity at Community Level**

The effective functioning of community groups for collective action and improving peoples’ health has yet to be demonstrated at scale through a government mechanism and system. NRHM presents many opportunities for partnerships and peoples’ involvement<sup>36</sup>. The NGO and CBO (community based organisations) can work together with the village health and sanitation committees to improve health.

Building capacity of the village health and sanitation committees to ensure quality and equitable health services to their communities is an intervention with great potential for sustainable development. The Institute of Health Management Pachod (IHMP) has worked out the process of organizing committees in villages and slums of Maharashtra. The crucial element of this process is involving community members in the functioning of the committee, outlining clear and defined roles for the committee and ensuring the application of democratic principles in the day to day functioning of the committee<sup>37</sup>.

### **State Level BCC Tasks & Responsibilities**

Defining the role of the state is essential for the operationalization of the proposed BCC strategy. There are seven key functions that the need to be performed at the state level to facilitate the effective implementation of the BCC strategy.

These are:

1. Broad strategy development
2. Organisation and distribution of work and responsibilities
3. Mass media development
4. Coordination
5. Capacity building and training
6. Planning Events for Special Health Days
7. Coordination with other government departments such as WCD, Education, Information and Publicity etc.

#### **1. Broad Strategy Development**

The state level BCC plan outlines a broad strategy that provides the foundation on which the district and block level plans can be structured. The state level plan is the conceptual backbone of BCC strategy development in Uttar Pradesh. The district and block plans will operationalize the proposed strategy.

The short term one-year plan has already been developed in this strategy document. The first task is to put this plan into action. The strategy envisages synchronized efforts between the mass media and

---

<sup>36</sup> SATHI-CEHAT “People begin “Occupation” and Direct Monitoring of CHC Pati, Barwani”.

[http://www.nrhmcommunityaction.org/media/documents/MP\\_Badwani\\_directmonitoring.pdf](http://www.nrhmcommunityaction.org/media/documents/MP_Badwani_directmonitoring.pdf); accessed Sept 17, 2008

<sup>37</sup> Dyalchand A. and Kapadia-Kundu, N. “People’s Committees: A gateway to grassroots democracy”, Health For The Millions, April-July 2004, vol 30 No 1& 2.

---

BCC at the community level. Rapid development of BCC materials and building capacity will be required. The state will have to build capacity at the village, block and district levels to implement this strategy document.

## **2. Organisation and Distribution of Work and Responsibilities**

NRHM provides an opportunity to provide integrated health services through a common set of grassroots and outreach providers. The BCC roles of each of these health personnel (ASHA, ANM, MPW, LHV, Anganwadi worker) need to be clearly defined and the work distributed. In addition, the cadre of DHEIOs, HEOs, DPMs, DCMs need to assigned specific BCC roles. The state has to define these roles and review and monitor the work.

## **3. Mass Media Development**

The development of mass media materials (radio, TV, print) is the responsibility of the State. SIPFSA, with its past experience in implementing large scale mass-media campaigns and in working with national level advertising agencies could be assigned this responsibility to develop, modify and adapt materials. The development of large scale media campaigns such as the behaviour change, provider and community entitlement campaigns should be given to professional agencies so that persuasive, behaviour specific and relevant materials are produced.

There are alternative multi-media options now available in rural India. These include mobile phones with cameras, mobile phones with FM radios, text messaging etc. These newer technologies need to be tapped to maximize audience reach in areas where power is scarce, since they work on batteries. The VHND campaign proposes to include a telephone number that can be called in case the VHND is not held on the stipulated day as planned. The state has the responsibility of tracking the reach and effectiveness of the media campaign.

### **Build Capacity to Develop Locally Appropriate Print and Audio-Visual Material**

There is very little production of AV materials at the district level. However, a decentralised approach is necessary where district HEIOs (Health Education and Information Officer) can plan, pre-test and produce their own BCC materials. The development of locally appropriate materials requires that BCC staff from the health department use a bottom-up approach towards materials development. BCC officials should view themselves as facilitators and not creators of BCC materials.

If a script needs to be prepared, grassroots talent should be tapped to ensure the appropriate use of local lexicon, images and ideas. The materials prepared should follow the content identified in the behavioural analysis. The materials prepared should be adequately pre-tested prior to printing.

The distribution of the material should be planned according to the type and frequency of media reach desired. The distribution system should take into account where the material is to be distributed (household or group level) and where it is to be displayed.

The following issues need to be considered when preparing material at the district level:

- a. To decide the type of AV material and the quantity required
- b. To prepare site specific materials focussing on the barriers to behaviour change
- c. To systematically pre-test AV materials before finalising them
- d. To modify, finalise and produce AV materials

If capacity to develop good quality materials is not available at the district level, then the state should get region specific inputs and assist in the production of materials

---

#### 4. Coordination

Coordination is a crucial function as NRHM since it covers 10 national health programs. A well-orchestrated BCC strategy should prevent a situation of overlapping and contradictory messages at least at the broader mass media level. Coordination is much more complex at the state and district levels than at the village or sub-centre levels. It is necessary for each programme to designate a nodal BCC officer who can undertake the role of coordination of BCC activities with the proposed BCC Cell within the NRHM Directorate.

Coordination is also necessary with PRI institutions (Panchayati Raj Institutions), ICDS (integrated child development scheme), WCD (women and child welfare department) and NABARD. The most important way of coordinating with them would be to provide them with BCC materials and have them participate in the on-going campaigns. For example, the list of priority behaviours should be circulated to all departments and a NRHM year planner with the 12 priority should be produced. Kits with BCC materials related to the 12 priority behaviours should be available at the IEC Bureau and BCC State Resource Centre. The involvement of other departments is crucial to creating a community level environment that is open to behavioural changes.

#### 5. Capacity Building

There is a need to build BCC capacity at the conceptual, planning and communication skill levels. Conceptual clarity of BCC is crucial as currently most programme managers and even policy makers are in the “information transmission” paradigm as a result of which “provision of more information” is viewed as the only way to fulfil BCC objectives. Therefore the common assumption that “ignorance of women and villagers” is the main reason for low behavioural change. However it is necessary to build a “behaviour change” perspective in BCC managers and planners and move away from the “information provision” perspective (for details on capacity building refer Chapter 11).

BCC capacity has to be built in the state at the state, district, block, and sub centre and village levels. It will be a State level responsibility to plan and implement this large-scale capacity building BCC initiative.

#### 6. Planning events during various health & development days (almost one per month)

The special events listed in detail in table 5.1 offer opportunities for generating not only awareness but community participation which can be used effectively to make an impact on the collective consciousness of the community. These also offer opportunities for using media to highlight social issues and create an enabling environment for changing social norms and behaviour change.

#### 7. Coordination with other government departments such as WCD, Education, Information and Publicity etc.

Well planned inter-departmental coordination with departments like education, WCD, Directorate of Field Publicity and Panchayati Raj institutions can extend the reach of BCC exposure. An orientation of the broad BCC strategy, priority behaviours and a discussion of areas of collaboration can be mutually beneficial.

#### Institutional Mechanisms for Implementing the BCC Strategy

There is need to outline institutional mechanisms that will facilitate the implementation of this strategy across the state. An institutional BCC assessment undertaken by UNICEF in 2007 for seven EAG states indicates the following situation in Uttar Pradesh<sup>38</sup>:

- Available BCC positions in UP are staffed at 22 percent, 23 percent and 13 percent respectively at the state, district and block levels. The situation at the block level has

recently changed with the appointment of some 550 block level BCC officers in 2008. Only 16 of the 70 sanctioned HEIO positions are currently filled. The UNICEF report recommends taking district HEIOs on contract.

- The Health Education Bureau and IEC Bureau have not been merged in UP.
- The technical capacity for planning and implementing behaviour focussed BCC programs at scale is lacking. Interviews with persons at the IEC Bureau indicate that it does not have the technical capacity for taking this strategy into action

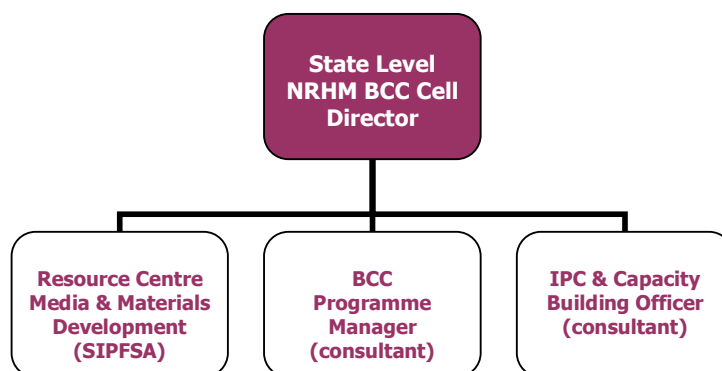
The above scenario poses a challenge in terms of implementing the proposed BCC strategy. In the existing scenario a two pronged strategy for building state, district and block capacities will have to be adopted - short term and long term. Strengthening the IEC Bureau will have to be achieved as a long term goal. The UNICEF Report recommends the appointment of a team leader (implementation and monitoring) and one officer each for mass media and IPC/folk media.

The short term strategy means that immediate responsibility has to be assigned to initiate implementation. Therefore it is recommended that SIFPSA could undertake the role of mass media planning and development. The State will have to take a decision to appoint a BCC Director, and the three positions recommended in the UNICEF report.

BCC Area	Responsibility: Person/Org
BCC Planning & Leadership	Director, BCC
Strategic Planning and Implementation	Team leader /BCC Cell/SPMU
Mass Media Planning & Development	SIFPSA
IPC & Capacity Building	Officer/BCC Cell/SPMU
Monitoring & Evaluation	Officer/BCC Cell/SPMU
State BCC Resource Centre	SIFPSA

The development of the IEC Bureau will have to part of the long term strategy BCC strategy of the state. In the short term, a BCC Cell within the NRHM SPMU is proposed. This will facilitate immediate implementation. The cell will have the three positions suggested in the UNICEF report<sup>38</sup>. The development and planning of mass media will be with SIFPSA. SIFPSA was established in 1994 and has a considerable BCC capacity in terms of materials development. It has implemented one of the most well planned BCC campaigns in the state “Aao Batein Karein”.

**Figure 6.1 NRHM BCC Cell**



<sup>38</sup> UNICEF, MSG Strategic Consulting (2007) “Draft Report on Enhanced Capacity of Government Partners for BCC”

---

The job responsibilities of the Director BCC Cell, BCC programme manager and IPC officer have been worked out in detail in Annex 8 of the UNICEF report<sup>38</sup>.

### **The State BCC Resource Centre**

A State BCC Resource Centre is proposed. This Centre will work with the latest and emerging technologies to increase the reach and effectiveness of persuasive communications to all parts of rural Uttar Pradesh. Alternatives to electronic media such as television and radio are:

(1) TV and radio spots played on CD via a DVD or VCD player in villages/urban slums during VHND (Khushali Diwas), local events, sub-centres, PHCs, private doctors clinics etc.

(2) Adapting the existing 57 page “*Aao Batein Karein*” family planning flipbook into shorter modules in a PowerPoint format with music and voice over added on. This can be shown during group meetings; at PHCs.

(3) Developing short films on BCC training modules so that training can be decentralized and the core training content is delivered uniformly. For example, a short film/presentation on “how to make a home visit” or “how to conduct a group meeting” can be developed easily and quickly. Then training ASHAs on both these tasks can be done by the block BCC officer at the block PHC.

The role of the state resource centre would provide on-line BCC resources for the districts in the following areas:

- a. Media materials & BCC guidelines
- b. List of behaviours and samples of behavioural analysis
- c. BCC planning and implementation frameworks and guidelines
- d. Samples, templates etc. that can assist districts in developing materials

### **On-line Resources**

1. Provide on-line resources for the districts such as:
  - Photo library; Templates for banners, wall paintings, posters etc.
  - Guidelines for VHND, group meeting, home visit and IPC
  - Samples of press releases, PPT orientation on basics of BCC
  - BCC monitoring formats, BCC training manuals
  - List of key behaviours, State Strategic Plan, District BCC plan
  - TV/Radio spots on organized by different behaviours (which then the district BCC staff can copy on a CD and use according to local need)
2. To use the internet to transfer materials and ideas developed at the district level to the state for professional production.
3. To provide BCC prototypes by each National Programme on-line so that districts can quickly prepare materials to counter any outbreaks or address district specific needs.
4. To provide an Internet forum where block BCC officers can post photographs and experiences of local events; case studies of problem solving etc.
5. To make district-wise data available on key behavioural factors for block BCC officers; to provide a list of NGOs by district etc.

---

## Implementation of the NRHM BCC Strategy in Uttar Pradesh

This BCC strategy also includes all the national health programs and the overarching strategy proposed in Chapter 4 is applicable to all programs. One-year Gantt charts (Chapter 5) have been developed for all the national programs. It is recommended that the BCC Cell at the NRHM Directorate be responsible for the BCC implementation of the RCH, Immunization and NRHM Initiatives.<sup>39</sup>

The UNICEF report states that the Vector Borne Diseases programme does not have a person to manage BCC. It is recommended that all the National programs can appoint a BCC nodal officer. An NRHM monthly review meeting should be held with the Director BCC.

---

<sup>39</sup> The UNICEF report also suggests that the IEC Bureau should be responsible for Sections A, B and C of the NRHM document. In the UP context, however, it is being proposed that State BCC Cell with the help of SIFPSA should undertake the responsibility of implementing the BCC programme. The state will have to plan in the long term to revamp its IEC Bureau.

## Long Term Strategic Plan

### District, Block & Village Level BCC Tasks & Responsibilities

A significant portion of the BCC work will actually occur at the district, block and village levels. A defined BCC structure at the district level is required that will manage and implement the BCC component of various health programs. The DHIO (district health and information officer) is the person in-charge of BCC at the district level. At the block level, there is the PHC Medical Officer. Recently, BCC officers have been appointed at the block level. This officer has the potential to ensure implementation of the BCC programme and provide it with impetus and leadership.

The frontline BCC workers are the ANM, MPW, AWW and ASHA. These existing resources are the key foot soldiers of BCC. The ASHA (about 100 in a block) is a valuable resource for providing community level BCC. Community resources such as women's groups, local groups, school children etc. represent untapped resources that can transform BCC efforts into sustainable behaviour change. The ANM will combine her BCC work with on-going service provision (no new BCC workload added). The MPW will have the responsibility of managing the vector borne diseases and TB programs. The anganwadi worker will be responsible for children under six years.

District level BCC cells have been proposed in the strategy document. The establishment of these cells will be the responsibility of the district level BCC officer. The functions of the district BCC cell will be:

1. To serve as a resource centre for BCC materials at the district level. The district BCC cell will stock print and electronic BCC materials related to all NRHM programs. Block level officials procure materials from these centres.
2. To manage and track the distribution of BCC materials from the district to village levels.
3. To develop local, need based materials through the use and adaptation of on-line BCC resources provided by the State BCC Centre.
4. To send monthly progress reports to the State BCC Centre<sup>40</sup>.

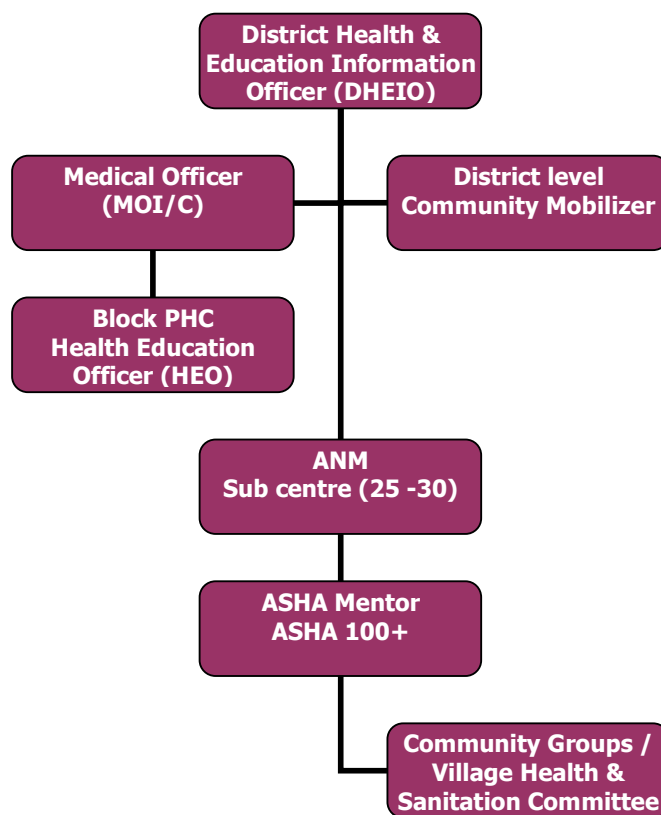
Figure 7.1 depicts the BCC implementation structure from district to community level. Local mass media and BCC at the community and family levels have been put at the forefront of the BCC strategy. The key to effective implementation is the strengthening and capacity building of the district, block and village level implementation structure.

The job definitions of the district BCC officer (DHEIO) and the block BCC officer have been provided in this chapter. Their primary BCC role is that of a manager - to organize, implement and supervise BCC activities in the district. The crucial skill for this job is that of BCC planning, supervision and monitoring.

<sup>40</sup> The UNICEF report on strengthening IEC Bureaus notes that there is almost no linkage between the IEC Bureau (at a state level) and the DHEIOs (district health education and information officer).



Figure 7.1 BCC Implementation Structure at District, Block & Village Levels



**1. District Level:** District Health Education and Information Officers (DHEIO)/ District Community Mobilizer

The job definition of DHEIO / DCM has been divided into the following categories: planning, training, materials development and management and distribution of BCC materials:

**A. Planning and Organizing Tasks**

1. To establish a district BCC cell
2. To prepare the district BCC plan
3. To prepare the BCC activity plan for District/ Block PHC /sub-centre
4. To implement outbreak management and prevention campaigns in the districts prone to outbreaks
5. To develop a good distribution and racking system for BCC materials

**B. Training Tasks**

1. To prepare BCC training plans
2. To prepare annual training schedules

- 
3. To conduct training of trainers at the district level
  4. To conduct monthly meetings with block BCC officers
  5. To monitor training activities

#### **C. Materials Development**

1. To adapt BCC materials and access them from the on-line BCC Resource Centre
2. To systematically pre-test BCC materials
3. To modify/adapt BCC materials

#### **D. Management and Distribution of BCC materials**

1. To organize BCC Materials (print, audio and video) and establish system where people can come to the district BCC cell to procure materials
2. To organize BCC materials by NRHM Programs
3. To maintain a digitalized CD library of materials and short films (procured from State BCC Cell)
2. To develop population based distribution criteria for BCC materials
3. To establish a distribution system for BCC materials
4. To include distribution of BCC material as a monitoring indicator
5. To develop monitoring formats
6. To send a monthly report to the State BCC Cell/IEC Bureau

### **2. Block Level: Health Education BCC OFFICER(HEO)**

The establishment of effective BCC management systems requires the creation of supervision and monitoring mechanisms. Supervisory staff requires training in supportive supervision for the effective implementation of BCC programs. The job definition of the block level Health Education BCC officer (HEO) is presented below:

#### **A. Planning Tasks**

1. To collect information to prepare annual block BCC plan
2. To prepare annual and monthly block BCC action plan for PHC /sub-centre
3. To prepare annual calendar of BCC events at the village and block levels.
4. To identify villages with low health coverage; identify high risk villages in terms of maternal, neonatal and child mortality
5. To take a monthly review & progress report of BCC activities in the block
6. To plan for VHND at the village level and provide supportive supervisory visits
7. To enable quality of BCC activities by ensuring that activities are implemented according to guidelines (saas bahu sammellans (mother-in-law daughter-in-law mass meetings), melas (fairs), group meetings and home visits).
8. To plan six monthly NSV/female sterilization campaigns.

#### **B. Implementation Tasks**

1. To ensure that monthly VHND is held in every village.

2. To monitor BCC inputs and BCC service coverage.
3. To identify villages with low ANC and RI coverage.
4. To check whether ASHA home visits cover the most vulnerable and disadvantaged areas in the village.
5. To assess and strengthen communication skills of ASHA
6. To prioritize visits to low coverage and/or high risk villages.

### C. Training Tasks

1. To train Health Supervisors and LHV's (Lady Health Visitor) in supportive supervision
2. To provide BCC training to ASHAs and ANMs at block level
3. To train ASHAs and ANMs in appropriate use of BCC materials

### D. Development & Distribution of BCC Materials

1. To develop appropriate local materials
2. To establish a distribution system for BCC materials
3. To include distribution of BCC material as a monitoring indicator
4. To develop monitoring formats

### E. Proposed Monthly Work Plan for Block level Health Education BCC Officer (HEO)

Supportive Supervision Visits to Villages - 3 times a week (2 villages per day; 6 per week)

	Mon	Tues	Wed	Thurs	Fri	Sat
Week 1	Field ASHA supervision	Block Office VHND Planning	Field VHND	Record Keeping	Campaign Preparation	Field Visit
Week 2	Field ASHA supervision	Block Office VHND Planning	Field VHND	Record Keeping	Campaign Preparation	Field Visit
Week 3	Field ASHA supervision	Block Office VHND Planning	Field VHND	Record Keeping	District Level Meeting	Field Visit
Week 4	Field ASHA supervision	Block Office VHND Planning	Field VHND	Monthly Meeting	Preparing monthly report	Field Visit

## 3. Village Level: Accredited Social Health Activist (ASHA)

### A. BCC Workload for ASHA

The ASHA's BCC workload has been devised to enable her to provide more effective and efficient BCC at the family and village level. Also, the ASHA's BCC role has been defined as being one part of a BCC system that also includes other health providers and community resources. Systematic BCC inputs will go a long way in maximizing the ASHA's potential as a BCC provider. Interpersonal communication inputs can be provided by ASHAs to households through home visits. An estimated 2.3 crore (23

---

million) eligible women can be reached an average 5-6 times a year through bi-monthly home visits by the 1,30,000 ASHAs in UP.

The ASHAs interviewed during the development of this strategy paper had no fixed home visit schedule. Some said they went to their field area once a week, some said twice a week while others said they went occasionally. Clearly, all the ASHAs interviewed perceived JSY as their main work and did not have clarity on their other BCC roles.

ASHA's BCC workload can be divided into the following tasks:

- BCC for women's health, maternal health, child health, family planning through home visits
- Group meetings with women as per campaign theme
- Motivating pregnant women, caretakers of infants, TB patients etc. for VHND
- At least three antenatal home visits to pregnant women
- Two post natal visits - one within 48 hours and another between 3-7 days
- Two additional home visits for low birth weight babies
- Counselling of newly married couples for Family Planning and delaying of first birth
- Counselling of eligible couples for Family Planning - spacing between children or for adoption of permanent methods
- Motivation and reaching intended audience as per needs of the national health programs

**Estimation of Workload for ASHA for 1000 population**

- Total population = 1000
- Married couples = 180
- Pregnant women = 30
- Sterilized couples = 30
- Eligible couples = 120

**ASHA Home Visit Strategy for 6 Home Visits per eligible woman per year**

- Home visits twice a week 8 times a month
- 4-5 home visits per day/twice a week

**B. Home Visit Workload**

If an ASHA has to reach every eligible couple in her village about 6 times a year, she has to visit approximately 60 households a month. In addition she has to visit about 16 pregnant women a month; do about four post natal home visits. On an average, she has to visit about 70 households a month. A home visit within 48 hours and between 7-10 days after birth; 2 post natal visits by ASHA. To initiate the structured home visit, a workload of up to 50 home visits in a month are being proposed on the lines of the SIFPSA experience of community based worker scheme (CBD worker) in the NGO projects.

Mobilizing women, caretakers for VHND (pregnant women, caretakers of infants) etc. She also has to prepare a list with AWW of the following about 3-4 days before VHND.

1. Names of pregnant women
2. Names of infants requiring immunisation
3. Names of children requiring Vitamin A
4. Names of women requiring post natal visits
5. List of DOTS patients

Help organize logistics and motivate women to attend VHND session every month.

The ASHA has to conduct a group meeting once a month. Preferably she should select the “area” with the lowest coverage in terms of the topic she is covering that month. The topic and behaviours promoted during the group meetings will match those outlined in the 4 main campaign themes.

### C. Monthly Workload

The ASHA’s monthly workload is depicted below. A fixed day, twice a week schedule is recommended for ASHA home visits. This will enable systematic supervision and support for the ASHA during home visits and also assist in regular implementation. Monday and Tuesday are recommended as her home visits days. However, if she has a delivery case on her home visit day, she has to plan an alternate day for home visits.

There are many community resources who can assist the ASHA in her BCC work. One strategy is involving children (Bal Chetaks) to assist with RI motivation, implementation and follow up. The ASHA will have to coordinate with Bal Chetaks supervisor and update her/him on new births in the village.

The ASHA can also liaise with the Village Health and Sanitation Committee and bring to their attention health related needs and problems of families.

#### Monthly BCC Workload for ASHA

1. Home Visits: 4-5 HHs/day/2 days a week (total of 50 HV in a month)
2. VHND: once a month
3. Group Meeting: Once a month
4. Delivery Cases: Twice a month
5. PNC Cases : 2/month
6. Village health and sanitation Committee: 1/month

### D. Monthly Home Visit Schedule for ASHA

	Mon	Tues	Wed	Thurs	Fri	Sat
Week 1	HH Visit 4-5 HHs	HH Visit 4-5 HHs	Delivery 1			Field Visit
Week 2	HH Visit 4-5 HHs	HH Visit 4-5 HHs Preparing list of women & children eligible for ANC and RI	VHND ANM ASHA AWW			PNC Visit 2 For Delivery 1
Week 3	HH Visit 4-5 HHs	HH Visit 4-5 HHs		Health & Sanitation Committee Mtg	Delivery 1	
Week 4	HH Visit 4-5 HHs PNC Visit 1 for Delivery 2	Block Office VHND Planning	Group Meeting by ASHA	Sub Centre IUD day (refer women to sub-centre)	PNC Visit 2 For Delivery 2	

## BCC Guidelines:

### Interpersonal Communication, Community Based BCC Activities & Outreach Services , Mass Media

The integrated BCC strategy includes planned inputs at the mass media and community levels. Community based BCC activities enable sustained behavioural change. These community level activities aim to motivate individuals and families change their behaviour as well as ensure that outreach services are available at the village level as planned. The regular availability of outreach services, Convenience and access to services is an important determinant of service utilization. BCC inputs are required not only to increase demand for services but also to increase the level of community accountability of health services.

This chapter provides guidelines for implementing the above mentioned community based BCC activities to facilitate focussed inputs that are effective enough to generate behavioural change. The guidelines are indicative and can be adapted for local needs. The guidelines for group meetings and home visits can be applied to national programs.

1. Home visits by ASHA
2. Group Meetings by ASHA / ANM
3. VHND (Village Health and Nutrition Day)
4. Saas Bahu Sammelans
5. Health Melas
6. Mass media

#### A. Guidelines: Home Visit & Situation Specific BCC by ASHAs

The guidelines for home visits enable the rapid building of interpersonal skills in community level workers. These guidelines focus on developing different communication and assessment skills. They include -- how to ask questions and assess BCC needs; how to listen; how to diagnose behaviours that require change and how to provide persuasive inputs based on identified needs.

It is important to address specific needs of different individuals. Every household will have different reasons for health problems. These reasons need to be identified prior to provision of BCC inputs. Otherwise “general messages” will be preached without much behavioural change. To move households towards changing behaviours, their **specific situation** has to be identified and addressed. BCC should be provided **after** the community based worker has assessed the situation and the needs of the household. Situation specific BCC should be provided during the home visit.

An IPC tool is recommended as a job aid to enable the provision to need specific BCC at the household level.

---

### How to provide situation specific BCC?

- The worker has to assess the needs of the household with the assistance of an IPC tool
- She then provides BCC after taking into consideration the situation in the household

### Guidelines for Home Visit

- Greet the family
- Assess need of the household with the help of the IPC tool (checklist). This is done by asking specific questions
- Ascertain reasons why certain behaviours are performed or not performed
- Encourage positive/appropriate behaviours
- Identify one or two behaviours that require change in that household
- Address the reasons cited for non performance of the behaviour
- Provide options and solutions through dialogue with household members
- Repeat the main behavioural action 3-4 times
- Check the IPC tool to see if anything has been left out or forgotten
- Encourage discussion among family members and with neighbours
- Conclude by outlining what the household member/s have to do next

## B. Guidelines: Group Meetings by ANMs

Typically group meetings are held for a particular topic such as family planning, child health etc. and AV materials are selected to provide information on the topic. They are rarely based on barriers to behaviour change. However, the effectiveness of a group meeting is greatly enhanced if a planned strategy is used.

The guidelines for the group meeting are presented in three parts:

- The first part discusses the basic principles that should be followed for effective outcome oriented group meetings.
- The second part discusses the preparation prior to conducting a group meeting. The main aspect of the preparation is contacting the appropriate audience and motivating them to come for the meeting. Preparation also includes outlining the expected outcome of the meeting and its follow up activities.
- The third part describes how to conduct the group meeting.

### Part I: Basic Principles for Conducting Group Meetings

- Prioritise & decide on one-two behaviours to promote during a single meeting.
- Address the causes of these behaviours.
- Use participatory methods
- Repeat the main behaviours at least 4-5 times during the group meeting.
- When concluding the session tell people what they need to do in their daily routine to enable them to adopt a new behaviour.

- 
- When concluding the session tell the group that they must discuss what they learnt during the group meeting with their family and neighbours
  - Maintain linkages between the group meetings and home visits.

#### **Part II: Preparation prior to group meeting**

- Decide on venue and time
- Prepare list of selected audience
- Contact selected audience
- Identify output of the meeting (practice)
- List reasons for use/non use of behaviour
- Decide which participatory methods to use, use of community level role models
- Prepare key behavioural messages and plan to repeat them several times through the meeting
- Decide on AV material
- Train facilitator
- Decide ice breaker
- Include a message on discussing BCC with family and community members
- Plan conclusion and follow-up

#### **Part III Actual group meeting**

- Rapport building /sahridaya and ice breaker
- Assess criteria for audience selection
- Use of role models/ satisfied clients
- Use participatory methods
- Repeat/reinforce key messages
- Encourage discussion while conducting the session
- Confirm decisions, provide follow-up action

### **C. Guidelines: Village Health & Nutrition Day (VHND) / Khushali Diwas**

The monthly Village Health and Nutrition Day is planned in UP as a day where health services will be made available in the morning and BCC events will be held in the afternoon. The VHND provides an opportunity of creating an environment of community togetherness and fun filled activities in addition to service provision.



## Schedule of activities for VHND

Khushali Diwas - Village Health & Nutrition Day		
Mobilization	<b>Step 1:</b> ASHA prepares list of RI and ANC beneficiaries; list of beneficiaries for group meetings by topic	
	<b>Step 2:</b> 4-5 pairs of Bal Chetaks ensure that most infants in the village are brought for the RI session.	
Service Delivery at the village level	<b>10:00 – 11:30 am</b>	<b>Routine Immunization:</b> Infants + children for Vitamin A dose (about 15-20 children) 5-6 school children to mobilize; ANM to give immunization
	<b>11.30 to 1.00 pm</b>	<b>ANC check up + IFA+TT+BCC</b> (about 12-15 ANCs)
	<b>1.00 to 2.00 pm</b>	<b>Lunch</b>
	<b>3.00 to 4.00 pm</b>	<b>Group Meeting by ANM:</b> (refer details Annexure 7)
Community Event	<b>5.00 to 6.30 pm</b>	<b>Local community Event (to be organized by village health and sanitation committee and MPW)</b> <ul style="list-style-type: none"> <li>Felicitation of ANM / ASHA / Role Models</li> <li>Panel discussion</li> </ul>

BCC & Outreach services during VHND	
<b>1. Routine Immunization</b>	<b>2. Contraceptive services</b>
<b>3. ANC check ups</b>	<b>4. DOTS for TB</b>
<b>5. Local events as planned by village health and sanitation committee</b>	<b>6. BCC through group meetings</b>
<b>7. Child-community activities: Bal Chetaks responsible for ensuring complete immunization of infants; and booster shots and Vitamin A for older children</b>	

## D. Guidelines: Saas Bahu Sammellan at Village / Block / District Level (Mass Meeting with Mothers-in-law and Daughters-in-law)

The Saas Bahu sammellan can be planned as a local event during VHND/Khushali Diwas. The event could be of approximately 2 hours duration. The Saas Bahu sammellan has been piloted by SIFPSA with great success at the District level and the activity should be scaled up under the NRHM.

### Planning:

1. Contact and publicity for the Saas Bahu event. ASHA, AWW, Bal Chetaks to motivate Saas Bahu pairs to come for the event. Make sure all parts of the village are covered including the most marginalized sections. There should be minimum of 30 Saas Bahu pairs at the village level.

### Objectives of Saas Bahu sammellan:

- To procure the support of mothers-in-law for 3 ANC checkups and institutional delivery for all pregnant women in the village including their own daughter-in-law.
- To procure support of mothers-in-law and daughters-in-law for delaying first conception.
- To facilitate improved communication between mothers-in-law and daughters-in-law through interactive games and exercises.

- 
2. Select a person to conduct the event (MPW, NGO supervisor, etc.)
  3. Plan the programme including the list of activities.
    - a. Identify a mother-in-law who has provided support to her Bahu for 3 ANC check ups.
    - b. Identify a mother-in-law who endorses delay in first conception in newly wedded couples. Request them (in advance) to share their experience
  4. Invite Gram Panchayat members / Community influentials for the event
  5. Plan the games for the event: communication exercises, tug of war, Matka Phod, three legged race etc
  6. Plan an oath that would be taken by all mothers-in-law; one for all daughters-in-law. The oath should include the key behaviours/actions expected of the mothers-in-law.
  7. Decide if the oath is to be taken with “dijas”, candles or only oral. Plan according to convenience and availability of resources.
  8. Organize the venue and microphone arrangements;
  9. Organize prizes for games; there is Rs 500 budgeted for each village level Saas Bahu sammellan; review local resources and plan how to use RS 500

### Implementation

1. Welcome and objectives of the meeting
2. Icebreaker: Communication exercise.<sup>41</sup>
3. Tug of war
4. Story/Role play and discussion on need for 3 ANC behaviours
5. Experience sharing of 1 or 2 mothers-in-law who have provided support
6. Felicitation of “ideal” mothers-in-law (certificate etc.)
7. “Chalte-Bolte” game in which a facilitator spontaneously asks ANC related questions to women in the audience and gives a small gift if the answer is correct
8. Oath taking and wrap up (ensure that the main behaviours 3 ANC check ups and institutional delivery are reinforced during the wrap up session)

## E. Guidelines for Block level Swasthya Melas (Health Fairs)

### BCC Objectives

1. To counsel newly married couples on delaying first conception, couple communication, supporting a young wife etc. To provide “Badhai” kits to the couple.
2. To provide demonstrations of iron rich recipes (let people taste a few) and distribute pamphlets on iron rich foods and number of meals for adolescents girls and women through a “Food Stall”.
3. To orient mothers and caretakers on the colour coded routine immunization schedule through a game.

---

<sup>41</sup> Make mixed pairs of m-in-laws and d-in-laws; then make teams of 2 pairs each; for each team: for the first pair ask one daughter-in-law to tell her favorite food to her partner; the second pair: the mother-in-law of the woman in the first pair should tell her partner what her daughter-in-law’s favorite food is. Both pairs come forward and partners state what they have been told; if the mother-in-law is able to guess the correct favourite food of her partner, then they win. After the game, the message should be – mothers-in-law should welcome and support their daughters-in-law.

- 
4. To increase knowledge of priority behaviours by displaying banners and visuals (refer list of priority behaviours)

### **Planning**

1. Publicity for the Swasthya Melas through ASHA, ANM, AWW
2. A counsellor should be available for newly married couples
3. Establish a food stall; posters on nutrition and number of meals; guided tour of posters to people visiting the stall
4. Establish an RI stall; posters on RI; guided tour of posters to people visiting the stall
5. Develop banners that can be used for Swasthya Melas in the district
6. Plan linkages between health services and BCC activities; those coming for health services should be referred to the counsellor and the BCC stalls and vice versa

### **Implementation**

1. Display banners
2. Establish food and RI stalls
3. Distribute pamphlets and “Badhai” kits as appropriate
4. Plan recipe demonstrations every half hour; let people taste the food that has been prepared; select locally appropriate, low cost recipes
5. Guided tours of stalls
6. Conduct “Chattle-Bolte” game
7. Assess response to counsellor and if necessary provide another stall for “family life” counselling

## **F. Guidelines for implementation in Mass Media**

The planning, coordination and implementation of the mass media component of the BCC programs is a state level responsibility. The functions include:

1. Planning and implementing mass media campaigns
2. Co-ordinating the electronic and print media with the district headquarters
3. The distribution of AV materials received from the state /BCC Bureau
4. Building capacity at the district level to develop locally appropriate AV and print material

### **1. Planning and Implementing Mass Media Campaigns:**

Long-term phasing is central to the development of the state level BCC strategy. A co-ordinated mass media effort planned over a period of time will be much more effective than sporadic TV and radio spots on health issues. Special campaigns that have an identifiable theme sustained over time are necessary.

### **2. Coordinating Electronic and Print Media with the District Headquarters:**

The state officials responsible for BCC need to co-ordinate use of the various mass media channels available at the regional headquarters. These channels include the following:

- All India Radio/TV
- Selection of sites for hoarding/ wall paintings
- Organisation of press conferences, DHIO to prepare articles for AIR and Doordarshan

- 
- Observation / celebration of specific days.
  - Mobilising college / N.S.S. students for campaigns.
  - Locate folk media groups - provide them with appropriate scripts
  - List of cinema theatres, cable operators and video centres

### 3. Distribution of Print and AV Materials

The district has the responsibility of distributing AV materials received from the state or produced at the district level. Often, there is a significant time lag between receipt of materials and its distribution to the village level is enormous. A well-designed distribution system can solve this problem.

Distribution of BCC material should be monitored regularly. The distribution system should include the following:

1. A separate store section for BCC material under the control of the DHEIO
2. A stock book
3. Responsibility of distribution
4. Types of distribution:
  - BCC material to be distributed directly from district to PHC as needed.
  - BCC material to be dispatched by the PHC vehicle which comes to the district headquarters for monthly replenishment of supplies.

### 4. Establishing a Distribution System

The establishment of a good distribution system will require distribution systems from district to PHC, PHC to village and village to households (if required). Distribution at the village level should be need based. The tasks involved in establishing a distribution system include the following:

1. Develop criteria for distribution
2. Preparation of a list of recipients / PHCs /villages
3. Establish a distribution system
4. Develop a monitoring format for distribution of BCC material

### Guidelines for Development of Mass Media (Electronic, Print, Wall Paintings)

These guidelines describe a few basic principles and steps that need to be adhered to when developing campaign materials. They have been developed to enable uniform implementation in the state. The materials should follow a few common principles:

1. Select a priority behaviour/action and it should be the focal point of the TV / CD / radio spot or print materials
2. The persuasive content of the BCC software should focus on processes that are predominant in the Indian socio-cultural settings eg. Approval of elders, neighbours, kinship networks; instead of relying on the “rational/information” based content that is routinely used for persuasion. Use concepts such as “*kartavya*” (duty), “*sahridaya*” (compassion), “*puniya*” (spiritual merit), “*rasa*” (emotional well being) etc. It will be essential to undertake formative research to see how the above mentioned concepts are understood at a community level
3. Emphasize the message “communicate the content of this TV/CD spot to your family and neighbours”.

- 
4. The persuasive content should address the barriers to behaviour and provide options on how to overcome the barrier.
  5. Community efforts and solutions should be modelled in TV/CD spots.

#### **TV, CD and Radio Spots**

- The behaviour that is promoted should predominate the spot.
- If health service behaviour is being promoted, then it is necessary to mention when and where the services are available.
- The TV/radio spot must address the underlying barriers to the behaviour. For example, if the barrier is lack of transport, then TV spot should suggest options and alternatives of how to arrange transport.
- Role modelling of key socio-cultural elements is a good strategy. This could mean showing satisfied users; enacting a behavioural sequence; focussing on processes like family influence etc.
- Using local socio-cultural metaphors will enhance the relevance of the TV/CD/radio spot.
- Organizing a discussion/meeting around a TV or radio show will enhance its effectiveness. Encouraging people to discuss the TV/radio message with others will accelerate its assimilation into the community.

#### **2. Print Materials / Posters**

- Focus on the behaviour being promoted. Do not use slogans - if a slogan is used, it should state the expected action
- Show the action being promoted or at least mention it
- Use socio-culturally relevant images and language without cluttering with too many visuals
- Pre-test before printing
- Plan for distribution and use
- Place a poster strategically i.e. do not overcrowd a wall with too many posters

#### **3. Wall Writing**

- Do not use slogans; they will be read and forgotten
- Provide relevant information about services and facilities, Should try and use visuals if possible
- Plan them at places where people are waiting - bus stand, PHC, station etc.

#### **Wall writing should include the following information:**

- Services available at sub-centre /PNC /VHND
- Cost of services (including the services that are available free of cost)
- A complaint number to call if money is asked for free services
- Nearest health facility for maternal or neonatal complications
- Janani Suraksha Yojna & Nearest testing facility and names of DOTS volunteers

## Building BCC Capacity

The implementation of the proposed NRHM BCC strategy for Uttar Pradesh depends on the availability of human resources and the ability to build BCC capacity at all levels. BCC capacity needs to be developed to build conceptual skills, planning, monitoring and evaluation skills, communication skills, and skills to prepare behaviourally focussed BCC materials. UNICEF's report on strengthening BCC capacity in seven states in North India reports that Uttar Pradesh has several strategic BCC positions vacant. The recent appointment in the state of 550 BCC officers at the block level also provides an renewed opportunity to strengthen BCC capacity in programme planning and monitoring.

This chapter is divided into four sections:

1. What is Behaviour Change Communication and what are its conceptual skills
2. BCC Planning, monitoring and evaluation skills
3. BCC Communication Skills for ASHAs
4. Building Capacity of the State BCC Resource Centre

### 1. What is Behaviour Change Communication and what are its Conceptual Skills?

The basic conceptual perspective that needs to be built is that BCC is about changing specific behaviours - "well defined actions at the household, community and health service levels". These "well defined actions" have certain causes due to which they occur or don't occur. The behavioural causes leading towards action or obstructing it, will vary between communities and households. Capacity has to be built at strategic levels that all BCC planners and implementers (from State policy makers to ASHAs) should have the ability to assess reasons for behavioural practices or lack of it.

The following conceptual skills have to be developed in a wide spectrum of health care workers:

1. What is BCC and the key behavioural actions required to save lives and improve health
2. Understanding the determinants of behaviour
3. Principles of motivation and persuasive communication
4. Principles of how adults learn

A multimedia introduction to Behavior Change Communication for service providers is required for capacity building. The presentation should include the above-mentioned conceptual skills in the context of the BCC strategy developed for UP. The orientation will require about 1-2 hours of instructional time and can be integrated with on-going training programs.

<b>BCC Conceptual Capacity Building Plan</b>	
<b>Trainer</b>	<b>Trainee</b>
<b>BCC Expert</b>	Master Trainers (10-12)
<b>Master Trainers</b>	Block BCC Officers
<b>Block BCC Officers</b>	ANMs, MPWs, ASHAs, AWWs
<b>SIHFW</b>	CMOs, etc.
<b>Master Trainers</b>	Trainers in National Health Programs

### **What is Behaviour Change Communication?**

The common view of BCC is that of "awareness creation". However, there is a basic difference between BCC and IEC. The assumption with IEC is that creating awareness will automatically lead to behaviour change. Therefore the emphasis is on "creating messages".

BCC, on the other hand, recognizes that behaviour change is more about identifying the causes and barriers to behaviour change and overcoming the barriers. BCC is also about using persuasive techniques to demand health rights and to make public sector health services available and accessible to the neediest. BCC is about how new practices can be integrated into long standing social, cultural and communication systems. BCC is about changing specific behaviours – "well defined actions at the household, community and health service levels".

## **2. BCC Planning, Monitoring and Evaluation skills**

A long term strategy for the state would be the development of adequate capacity for BCC planning, monitoring and evaluation. Currently this BCC planning capacity is lacking in Uttar Pradesh <sup>38</sup>.

The capacity building efforts include development of skills to prepare district and block level BCC plans. This is crucial for effective implementation of the BCC strategy. In the first year (2008-2009), one sample district BCC plan should be prepared. One of the requirements for preparing district and block plans is the availability of reliable data at the PHC, sub-centre and village levels.

At the same time, the BCC block officers should be trained in effective implementation of BCC programs. The block BCC/HE officer's training is for 12 days. The first module of 4 days has been prepared by SIHFW. Modules 2 and 3 are BCC related and have been designed to build a strong planning and implementation base.

**Module 1:** Introduction to NRHM and different national programs (4 days)

**Module 2:** What is BCC and Communication Skills related to BCC (4 days)

**Module 3:** BCC Planning (4 days)

<b>BCC Block Level Officers : Course Objectives (Modules 2 and 3)</b>	
<b>1. BCC conceptual skills</b>	<ul style="list-style-type: none"> <li>• Linking BCC approaches to behaviour change</li> <li>• Principles of motivation and persuasive communication</li> </ul>
<b>2. Communication Skills</b>	<ul style="list-style-type: none"> <li>• How to assess the BCC needs of a household</li> <li>• How to provide BCC at the household level based on specific needs</li> <li>• How to conduct a group meeting</li> <li>• How to undertake a follow up visit at the household level</li> </ul>
<b>3. BCC Planning and Training skills:</b>	<ul style="list-style-type: none"> <li>• To train ASHAs and ANMs to develop and implement monthly BCC plans</li> <li>• To train ASHAs on how to conduct home visits and group meetings</li> <li>• To include local BCC events at the community level</li> <li>• To organize BCC workload of ASHA, ANM, Health Supervisor, BSW</li> <li>• To provide supportive supervision of ASHA and ANM</li> <li>• To monitor BCC at input, output and outcome levels</li> <li>• To coordinate block level BCC activities with on-going state level campaigns</li> </ul>
<i>A timetable for the BCC training of the block level BCC officers is enclosed in Annexure 10.</i>	

### **3. BCC Communication Skills for ASHAs: How to conduct home visits, group meetings etc.**

The third major area of capacity building is to provide basic BCC skills to ASHAs on how to conduct home visits and group meetings. These skills are essential for effective community based BCC implementation.

The following job aids and training tools are recommended for training ASHAs:

1. A short film/presentation on how to conduct a home visit
2. An IPC tool (job aid) to enable household needs assessment. The tool will focus on maternal and new born health in the first year. It can then be extended to include other areas of health.
3. Guidelines on conducting home visits and group meetings.
4. Field training and supportive supervision to enable ASHAs to provide effective interpersonal communication inputs during home visits.

The preparatory steps for equipping ASHAs with BCC skills are:

1. Adaptation of the IPC tool for maternal and newborn health
2. Preparing a short film/ presentation on how to conduct a home visit using the checklist
3. Training ASHAs in how to conduct home visits
4. Block BCC officers to provide in-service training on home visits and group meetings during monthly meetings at PHC
5. Block BCC officers to provide on-field demonstration and supervision to ASHA during home visits
6. On-going inputs on BCC through the ASHA newsletter



---

#### **4. Building Capacity of the State BCC Resource Centre**

The capacity of the State Resource Centre has to be developed in the following areas:

- Preparation of short films and presentations focussed on specific behaviours
- Provide templates of banners, press releases, pamphlets etc. that districts can use according to their local needs and requirements
- Electronically connected to districts
- Plan and monitor the distribution of CDs, etc. to districts
- Pilot the use of new technologies such as SMS and mobile phones
- Provide rapid BCC response to outbreaks with pre-planned campaigns
- Create a data base of BCC resources that can be used and adapted by district all over the state
- Build capacity in districts to develop their own materials
- Maintain an electronic forum of communication exchange with districts

## Supportive Supervision, Monitoring & Evaluation

**W**ell-planned supervision and monitoring are necessary for large scale implementation of BCC campaigns and for implementing BCC activities at the community level. This is one of the weakest links in the BCC efforts in the state. The systematic implementation of BCC strategies will be largely dependent on the establishment of effective supervision and monitoring systems.

Clear cut supervisory roles for BCC functions are often not defined. A BCC supervisor is expected to ensure that the BCC activities and inputs are implemented as planned. The supervisor will have monitor if the ASHAs are implementing their planned BCC tasks. Most importantly, they need to provide guidance and support to the community based frontline workers.

The BCC supervisors should be oriented to the BCC strategy. The supervisors should know of the 12 priority behaviours identified under NRHM and they need to promote the priority behaviours within their area of work. The BCC supervisor should conduct field based training and demonstrate problem solving skills to resolve field based difficulties.

### BCC Supervisory Checklist

1. Use of BCC materials.
2. Assessment of performance based on client satisfaction.
3. Discussion of field problems with community volunteers /link workers.
4. Check ability of the worker/volunteer to do micro planning.
5. Extra inputs to the worker they are weak in any area.
6. Village level coordination with ANM, anganwadi worker, community volunteers and supervisor.

The BCC supervision schedule will have to be worked out depending on the availability of human resources. However, ASHA will require supportive supervision to develop capacity for effective BCC during home visits. A Block BCC officer should plan at least a quarterly supervision visit to the ASHA. Alternately, the LHV's can be trained for the supervisory functions.

### Methods of Supervision

- Random surprise checks on work of frontline workers.
- Five houses to be covered with ASHA during a supervisory visit.
  - Observe her skills of conducting home visits. Provide her with supportive inputs and guidance.
  - Ask her about her high risk and/or resistant cases. Make it a point to visit households that are resistant.
- Check registration of people who attended group meetings - should include names of those who attended, the total no., and topic of the group meeting

---

## Monitoring

There is a need to establish an effective monitoring system for BCC. This system has to be developed for mass media as well as for community level BCC inputs. The monitoring system has to include indicators in the following areas:

- BCC inputs (home visits, group meetings, radio/TV/CD spots aired or not, VHND, distribution of posters, newsletter, whether wall paintings have been done as planned etc)
- BCC outputs include number of persons attended meeting, number of women covered through home visit, number of persons receiving media exposure.
- BCC outcomes are changes in behaviours.

### BCC Input & Output indicators

BCC input indicators	Level of Monitoring	Frequency
<b>Home Visits by ASHA</b>	Village Level	Monthly
<b>Group Meeting by ASHA /ANM</b>	Village Level	Monthly
<b>VHND</b>	Village	Monthly
<b>TV/Radio spots aired</b>	State, district (for cable TV)	Monthly
<b>CD Spots distribution</b>	State/district	Monthly
<b>CD Spots Use</b>	State/District/Block	Monthly
<b>Block BCC Events</b>	Block	Six Monthly
<b>Events on Health Days</b>	State	Monthly
<b>Community BCC approaches</b>	Village	Monthly
<b>Distribution of print media</b>	State/District	Monthly
<b>Display of print media (posters/wall paintings)</b>	Village/block/district	Monthly
<b>Sending BCC Materials to districts etc. (MNH Kits, BCC Calendars etc.)</b>	State/District/Block	Monthly
<b>Distribution of BCC materials to beneficiaries</b>	Village/PHC	Monthly

BCC output indicators	Level of Monitoring	Frequency
<b>1. Number of Home Visits by ASHA/Planned</b>	Village Level	Monthly
<b>2. Number of Persons attended Group Meeting by ASHA/Planned</b>	Village Level	Monthly
<b>3. Number of Women attended Group Meeting by ANM/Planned</b>	Village, Sub-centre	Monthly
<b>4. Number of Services Offered during VHND/Planned</b>	Village	Monthly
<b>5. No of persons viewed TV/Radio spots/Planned</b>	State, district (for cable TV)	Yearly
<b>6. Number of CD Spots distributed/planned</b>	State/district	Monthly
<b>7. No of persons viewed CD Spots/Planned</b>	State/District/Block	Yearly
<b>8. No. of persons attended VHND Local Event/Planned</b>	Village	Monthly
<b>9. No. of persons attended Block BCC Events/Planned</b>	Block	Six Monthly
<b>10. No. of Events Held on Health Days/Planned</b>	State	Yearly
<b>11. No. of persons viewed (posters/wall paintings)/Planned</b>	Village/block/district	Yearly
<b>12. Number of persons receiving BCC materials/Planned</b>	Village/PHC	Monthly

### Monitoring Behavioural Outcomes

It is recommended that priority should be given to establishing monitoring systems for BCC inputs and outputs. BCC outcomes (behaviours) are more conducive to annual monitoring, using a randomly selected sample. A BCC section can be added on to the ongoing SRS surveys or any large scale survey. This section should include the list of behaviours as per the needs of the health area being surveyed. A few questions on BCC inputs and outputs can also be included.

Behaviours to be monitored yearly	
Family Planning / Adolescent Health/ Nutrition	
1. Age at marriage	3. Eat iron rich and vitamin C food daily
2. Delay the first pregnancy	4. Eat three times a day
Delaying of the first birth Increase birth interval to three years	5. Adopt any limiting method after two children even if both are girls
Maternal & Neo natal Health	
6. Early registration <12 weeks	12. Stay in the hospital for 24 hrs after delivery
7. Eat four times a day (pregnant women)	13. Immediate and exclusive breast feeding within 1 hour
8. 3 ANC check ups	14. Get at least one PNC at home or at service facility immediately or latest within one week
9. IFA supplementation	15. Keep the baby warm
10. Care seeking for danger signs	16. Weigh the newborn within 24 hours
11. Institutional Delivery	17. Exclusive breast feeding for 6 months
Child Health	
18. Complete Immunization/Booster / Vit A	19. Complementary feeding from 6 months 4-5 times in addition to breast feeding
Tuberculosis	
20. Early identification of TB	21. Continue and complete treatment for the prescribed period
Malaria	
22. Empty and dry water containers for one day in a week	23. Inform VHSC/ASHA/ANM about outbreak
24. Get blood tested for malaria if suffering from fever	<b>25. Leprosy:</b> Early identification & treatment
<b>26. Blindness control:</b> Seek care if vision is unclear	

### Evaluation

There are very few good evaluation studies of BCC interventions implemented through the public sector. The UP BCC strategy promises to be one of the first state level planned BCC efforts in the country. It is very important to ascertain which interventions worked and which did not. Well designed community based BCC trials are rare and building an evidence base will serve not only Uttar Pradesh but the rest of the country as well.

Three types of evaluation studies are proposed:

- assessing the impact of pilot interventions

- 
- assessing the role of community based BCC approaches; community involvement approaches and mass media approaches in enabling behavioural change
  - formative research to assist in the development of culturally and socially relevant BCC materials.

### **1. Assessing the impact of pilot interventions**

Several BCC interventions will be piloted, many for the first time at scale. Therefore the following evaluation studies are recommended:

1. To assess impact of the Bal Chetak intervention on RI coverage
2. To assess impact of the SMS based campaign on male involvement and maternal health
3. To assess the impact of the VHSC
4. To test different models of ASHA home visits

### **2. Assessing the Effectiveness of Different BCC Approaches**

The following studies are proposed to assess effectiveness of different BCC approaches

1. A randomized cluster trial with three arms (community based BCC+ mass media; community based BCC + community involvement + mass media; comparison group) is proposed for evaluating BCC impact on selected maternal, new born care and family planning indicators.
2. A study to assess the impact of the BCC programme on anaemia prevention in unmarried adolescent girls in schools.

### **3. Formative Research**

1. Understanding concepts like “puniya”, “kartavya”, “sahridaya”
2. Understanding gender dynamics in homes with 2 daughters
3. Understanding communication flows, patterns and networks in rural families
4. Exploring concept of male involvement and responsibility
5. Ritual purity and pollution systems: birthing process; hygiene and sanitation; menstrual hygiene etc.

## Recommendations & Conclusions

**T**he strategy document is only a first step towards effective BCC in Uttar Pradesh. The real challenge lies in operationalizing these strategies to reach the neediest and most marginalized groups. The recommendations provided in this chapter are geared towards converting the ideas in this document into action.

### Immediate Next Steps

1. Appoint a nodal officer at the State level who can operationalize the one year plan
2. Prepare a monthly VHND plan for the state based on the number of villages an ANM covers. Prepare it for the entire year. Post this plan in every village. Include a complaint number that can be called if VHND is not held.
3. Use SMS to remind key people about the date and time of VHND including ANM, MPW, AWW and ASHA.
4. Get software from the Central government and existing software available with SIFPSA (as outlined in chapter on mass media) and start the electronic media campaign
5. Establish a committee at the state level that will meet quarterly to review the progress of implementation
6. Assign responsibilities to NGOs and development partners
7. Prepare detailed action plans for the strategic components : IPC, mass media and community involvement
8. Finalize details about the state BCC Innovations and prepare action plans to operationalize them
9. Use SIFPSA “Suvidha” (IUD) and female sterilization campaigns with GOI software
10. Use UNICEF teleserial “Kyon Ki Jeena Isi Ka Naam Hai”. Develop short CD spots on priority behaviours based on characters of the serial.
11. Translate and distribute this document in Hindi.

### Community Based BCC

1. Adapt the IPC checklist for maternal and newborn care.
2. Prepare a short training film/CD for ASHAs on how to conduct a home visit /use IPC checklist.
3. The IPC checklist and training toolkit should be sent to districts in three months.
4. Send out detailed guidelines on VHND; send these to the village health and sanitation committees too.
5. Plan promotion and distribution of ORS and BCC on hand washing with soap after defecation and before feeding child under three years during pulse polio rounds.

---

## Capacity Building

1. Undertake large scale orientation on BCC and the BCC strategy document for all health personnel. A one hour presentation on BCC should be developed that can be used for orientation.
2. Conduct a half day orientation of “What is BCC” and the key behaviours being proposed in the strategy document for CMO, deputy CMO and DHEIO (45 minute presentation that can be used by MO (in-charge)).
3. Prepare a plan on BCC orientation of ASHAs, ANMs etc. (may be done at the block PHC level)
4. Train block BCC officers in BCC planning and supervision
5. ASHAs to receive decentralized training at the PHC level on how to conduct home visits. This training will be conducted by the block BCC officer.

## Long term Steps

### Mass Media/ BCC Materials

1. Establish a BCC Resource Centre
2. SIFPSA to prepare mass media software including CD spots based on priority behaviours.
3. Start preparations for new campaigns. Assign agency and give them a detailed brief (as outlined in the strategy document).
4. Priority should be given to VHND.
5. Develop MNH kit for mother and newborn (assign responsibility to SIFPSA).
6. Develop kit for married couples.

### Capacity Building

1. Build capacity at the district and block levels for BCC planning for all blocks and districts
2. Build capacity to establish and maintain a BCC supervision and monitoring system
3. Build capacity to develop effective behaviour focussed materials.

### Monitoring and Evaluation

1. Establish a simple BCC monitoring system
2. Plan for a community level trial to assess impact of the state BCC strategy (details in chapter on monitoring and evaluation)
3. Assess the impact of pilot interventions
4. Undertake formative research to produce locally and culturally relevant BCC materials

## Conclusion

The implementation of the strategy document will require multiple efforts at different levels. The three main strategies - IPC and community based BCC, mass media and community involvement have to be initiated concurrently. At the same time, the work of capacity building and materials development also is required. The strategy document provides clear cut direction on the operational aspects of the strategy. Uttar Pradesh has taken a major step forward in initiating the development of a state level BCC strategy document. If effectively implemented, the NRHM BCC strategy can contribute towards saving lives of women and children and improving the health of the people of Uttar Pradesh.



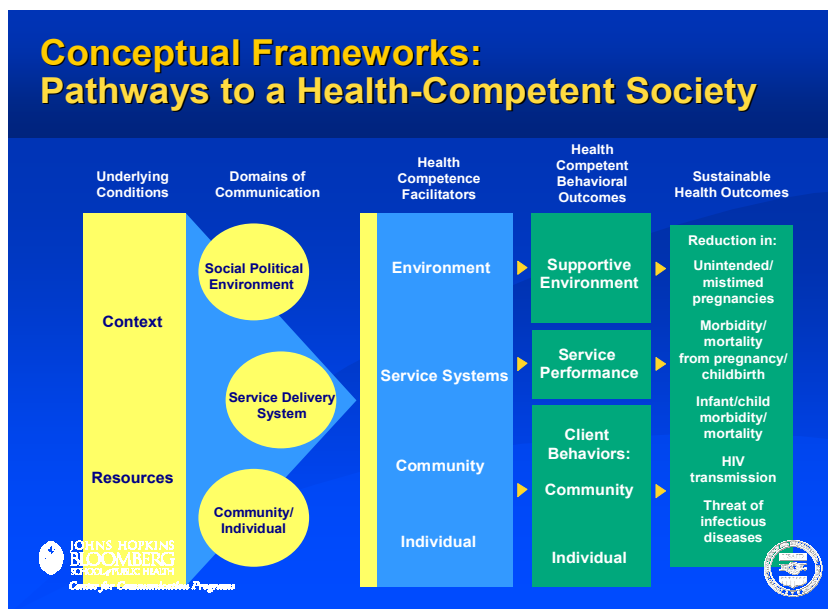
# Annexures

## Annexure 1

### BCC Conceptual Framework

CCP's overall strategic approach to achieve social change, and specifically to address pressing health needs in Uttar Pradesh, follows the Pathways model for program design, implementation, and evaluation. CCP developed the Pathways model in collaboration with USAID to summarize a process for developing health communication interventions for a health competent society, based on program experience and health behaviour change models. The proposed intervention for Uttar Pradesh uses the Pathways model as a guide.

One of the perceived strengths of the model is that it focuses on concrete steps that lead to behaviour change, starting with an analysis of the underlying context and resources. This conceptual framework is a structural-environmental model that provides a structure for coordinated activities at the individual, community, organizational and policy levels.



---

### Domains of intervention:

The communication plan seeks to mobilize social and individual change by addressing health issues across two main domains of the pathways: Service delivery and individual/ community domains of communication. Within the Service Delivery domain of intervention the plan seeks to improve quality of care by addressing interpersonal communication and counselling skills of providers using mass media, training, and print materials. The plan also seeks to scale up the work of NGOs and other potential partners (i.e. donor and cooperating agencies). The project's strategic and multidimensional efforts will create a supportive environment for higher quality services and sustained related health behaviours among target audiences.

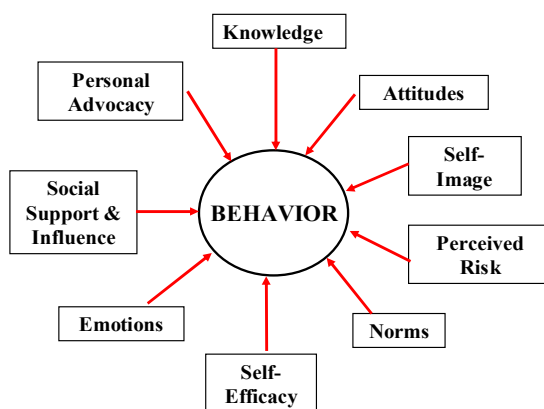
At the community/Individual domain of intervention the plan seeks to change community and individual health behaviours, knowledge, efficacy and social norms, through interpersonal communication and counselling, mass media and community-based activities. The approach to change individual behaviour is based on the well-researched ideational behaviour change model proposed by Johns Hopkins , which recognizes that a new behaviour has better chances to be adopted when:

- People have gained sufficient knowledge about the communication subject
- The individuals have developed a positive attitude towards the communication subject
- People start talking to others about the communication subject, and
- People feel right about adopting the behaviour proposed.

The model acknowledges that many factors influence behaviour and that a communication intervention can address several of them simultaneously to increase the probability that a new behaviour is adopted.

This concept can be better appreciated in the following graph:

### Influence of Ideational Elements on Behavior



---

## Sadharanikaran: An Ancient Indian Theory of Communication

Sadharanikaran means simplification without dilution; simplification while retaining the essence and meaning of the matter that is to be communicated. This ancient Indian concept of simplification resonates powerfully in today's world as we attempt to transmit comprehensive health messages to large audiences.

Sadharanikaran is an ancient Indian theory of communication based on the second century BC treatise of dance and drama, the "*Natyashashtra*". The theory's relevance to health behavior and public health lies in its inclusion of constructs such as emotion (*rasa*), compassion (*sahridaya*), social influence, hierarchical patterns of communication and simplification; constructs that do not usually find a mention in most existing behaviors change theories. Sadharanikaran permits us to take a new look at understanding the processes and elements of behaviors change.

### Sadharanikaran: An Indian Theory of Communication

"*Sadharanikaran*" was developed in ancient India and contains elements which are central to how communication processes occur in India (Tewari, 1980; Yadava, 1987). Sadharanikaran combines elements of social cohesion, emotional fervour, compassion and hierarchy, all of which are critical micro processes in determining patterns of behaviour.

*Sadharanikaran* is based on a classical Indian text on dance, drama aesthetic theory, the "*Natyashashtra*", written by the sage Bharat Muni between second century B.C. and first century A.D. (Yadava, 1987). The four Vedas are the oldest Hindu scriptures and are written in Sanskrit. However, the *Natyashashtra* was written in Pali, the language of the common people and is considered the fifth Veda, Bharat.

The development of the *Natyashashtra* spans a period of 700 years after Bharat Muni's initial rendition. It evolved with appraisals from several critics through the years. Most of the commentaries on the *Natyashashtra* written prior to the tenth century AD. are lost. We learn about them in the young Kashmiri philosopher, Abhinavagupta's commentary on the *Natyashashtra* written in 100 AD. It is largely Abhinavagupta's contribution that led to the development of a full fledged theory of Aesthetics based on the *Natyashashtra* (Gnoli, 1956; Kale, 1974; Pandey, 1959).

The links to communication theory are apparent. For example, the *Natyashashtra* is presented from three points of view - the dramatist, the actor and the spectator. In today's communication terms we would use source, channel and receiver. The communication process as outlined in the *Natyashashtra* can be applied to persuasive communications in today's world. This is plausible because the *Natyashashtra* deals with the technicalities of audience response, which in a sense, parallels the goals of persuasive communications. It also lists the barriers that prevent "real" communication from occurring.

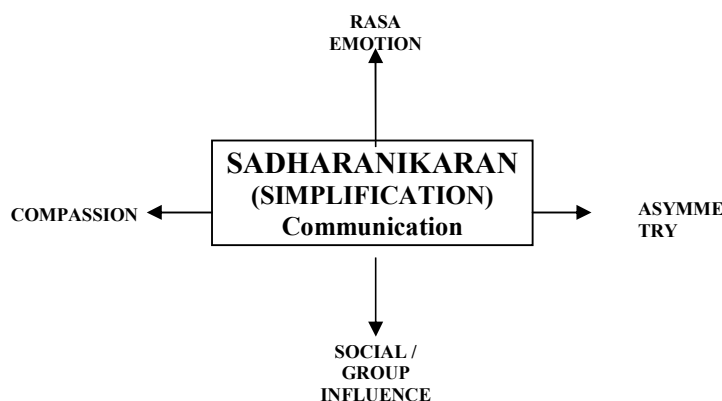
Yadava (1987) states that *Sadharanikaran* is a valid framework to study communication processes in India. He concludes that four of the five tenets of *Sadharanikaran* can be applied to the understanding of present day communication processes in India. The essence of *Sadharanikaran* embodies the relational, emotional and aesthetic aspects of the communication process. It is an audience oriented theory (Rahim, 1987).

---

The five tenets of Sadharanikaran are:

- **Sahridaya (shared compassion):** “Emotion is about relationship not individual, about process not states” (Timm, 1991, p.63). *Sahridaya* denotes the common compassion between source and receiver. It represents the relational aspect of communication and emphasizes a non-cognitive dimension of communication.
- **Rasa (emotional arousal & aesthetic):** Focuses on the reaction invoked in the audience. To achieve *rasa utpathi* seven permanent moods have to be aroused. The principles of Sadharanikaran first appeared in a treatise on dance and drama, hence the focus on emotion. The source should evoke reactions in the audience which lead to a feeling of bliss and being in harmony.
- **Universalization /Social Influence:** This refers to collective phenomena at a group level.
- **Simplification:** This principle implies the process of simplification of concepts through the use of folklore, metaphors and illustrations. Says Yadava (1987) “this approach makes communication a dynamic, flexible, practical and effective instrument of social relationships and control”(p:169)
- **Asymmetry:** Asymmetry means communication flow from the source to the receiver. This is particularly true in the context of the highly stratified structure of Indian society.

#### Sadharanikaran: An Ancient Indian Theory of Communication



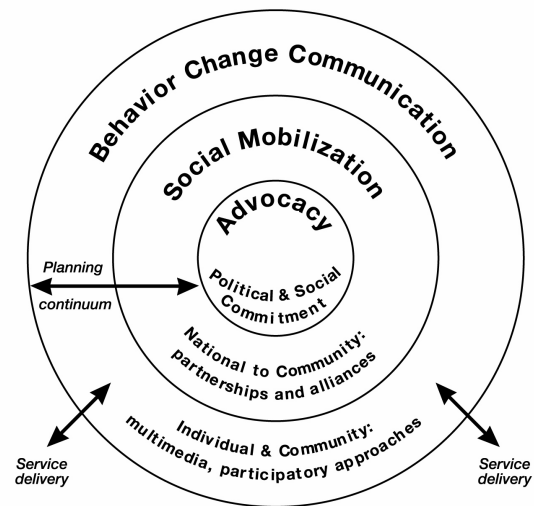
The empirical support for Sadharanikaran comes from its application to evaluating a child-to-community (Bal Sevak) intervention to change hand washing behaviour. The *Sadharanikaran* framework will allow the exploration of important non-cognitive elements of the *Bal Sevak* intervention. Children readily evoke emotions. In this instance, it is essential to measure the audience response to the child as a communicator. Simplification is the key guiding principle to the *Bal Sevak* strategy. All the tenets of *Sadharanikaran* – compassion, emotional arousal, aesthetic pleasure, simplification and asymmetry are applicable to the *Bal Sevak* intervention.

*Sadharanikaran's* value as an audience based theory lies in its ability to explicate beyond individual response to collective response. *Sadharanikaran*, by assigning equal weight to source, channel and receiver provides a framework for a more holistic appraisal of the situation.

Kapadia-Kundu, N. (1994) *An empirical test of the Sadharanikaran theory of communication to defecation hygiene behaviour: An evaluation of a child-to-community intervention in Maharashtra, India. PhD Thesis submitted to the Johns Hopkins School of Hygiene and Public Health*

---

Figure 3-1: Strategic Communication Components (Source: McKee et al., 2000)



---

## Annexure 2

### Continuum of Care Health Packages for Maternal, Newborn and Child Health

#### I Clinical Care

1. Reproductive health clinical care package
2. Childbirth clinical care package
3. Newborn and child clinical care package

#### II Outreach Services (or OPD services)

1. Reproductive health package
2. Antenatal care package
3. Post natal care package
4. Child health package

#### III. Family and Community Care

Promote healthy household and individual behaviours related to hygiene, nutrition, safe water, safe environment etc. Also increase a demand for service behaviours and increase the capacity to recognize danger signs and plan for emergencies.

Kerber, K. et al (2007) "Continuum of care for maternal, newborn and child health: from slogan to service delivery" Lancet, vol. 370 , Oct 13, pp 1358-1369

## Annexure 3

### Interviews with Policy Makers and Stakeholders

	Date	Name	Designation
1.	7/8/2008	Aradhana Johri IAS	Jt Secretary, MOHFW, Government of India
2.	24/6/2008	Rajeev Kapoor IAS	Secretary, MHFW & Mission Director, NRHM Executive Director, SIFPSA, Uttar Pradesh
3.	24/6/2008	Dr A. K. Mishra	State Epidemiologist, Programme Officer, Filial, Japanese Encephalitis, Bird Flu
4.	24/6/2008	Dr Shalini Raman	Deputy Director, IEC, UPSACS
5.	24/6/2008	Dr. C. B. Prasad	Director, Family Planning, Uttar Pradesh
6.	25/6/2008	Dr Ram Swarup	Deputy CMO, Sitapur District, UP
7.	25/6/2008	Group Discussion with 14 ASHAs	Reuwsa CHC, Sitapur District, UP
8.	25/6/2008	Rama Devi	ANM, Sitapur District, UP
9.	25/6/2008	Dr Neera Jain	Director, SIFHW, UP
10.	26/6/2008	Dr S K Jain	Director, MCH, UP
11.	26/6/2008	Group Interview Dr Madhu Sharma	DGM, NRHM
12.	26/6/2008	Group Interview Dr Brijendra Singh	Consultant, SPMU, UP
13.	26/6/2008	Group Interview Dr A. Mishra	GM, NRHM
14.	26/6/2008	Dr J. Rai	Jt Director, RNTPC, Uttar Pradesh
15.	26/6/2008	Group Interview Dr L.K. Aggarwal, Dr S. K. Varma, Ajay Mishra	Jt Director, MCH, UP IEC Bureau, UP
16.	26/6/2008	Dr Vishvajeet Kumar	International Health Dept, Johns Hopkins School of Public Health
17.	26/6/2008	Rashmi Sinha	Director, Mahila Samkhaya
18.	27/6/2008	Kanti Devi	ASHA, Shyamdaspur Village, Bharawan PHC, Hardoi District
19.	27/6/2008	Gudiya Devi	ASHA, Jajupur Village, Bharawan PHC, Hardoi District
20.	27/6/2008	Brief Group Session with 50-60 ASHAs	Bharawan PHC, Hardoi District
21.	27/6/2008	Brief Discussion	Medical Officer, Bharawan PHC
22.	28/6/2008	First Core Group Meeting	List of Core Group Members attached
23.	28/6/2008	Mr Augustine Veliath	UNICEF, Lucknow
24.	23/7/2008	Group Interview Om Prakash Yadav	Block Officer, Trivediganj PHC
25.	23/7/2008	Group Interview K. P. Tiwari Dr Neelima Singh	Health Supervisor, Trivediganj PHC DHEIO, Barabanki district
26.	24/7/2008	Second Meeting: Core Group	

---

## Interview Guide: Policy Makers

Sr No \_\_\_\_\_

Date of Interview \_\_\_\_\_

Please Note: This guide has been prepared for the NRHM Mission Director. Some of the general questions will become programme specific when Directors of National Health Programs are interviewed.

1. Name \_\_\_\_\_ 2. Sex: \_\_\_\_\_

3. Designation \_\_\_\_\_

We would like to request about 45 minutes to 1 hour of your time to discuss the development of a BCC strategy document in the context of NRHM for Uttar Pradesh. The need for developing a BCC strategy has been stated in the UP Programme Implementation Plan (PIP). Your experience and expertise in developing and implementing health policies and programs in UP will be crucial to making this strategy document feasible and amenable to effective implementation.

### I Health Priorities

1. In your opinion, which are the 3 biggest health problems in Uttar Pradesh? And why?
2. NFHS-3 data indicate that maternal care coverage indicators are still low - 22 percent receive at least 3 antenatal visits. Further analysis shows that there is little regional variation in coverage - all seem to be on the lower side. What are the reasons for low maternal care coverage?
3. From all the national health programs, FP, RCH, Blindness Control, TB, Vector Borne Diseases, Leprosy Control, which do you think are **most effectively** implemented? Why?
4. From all the national health programs, FP, RCH, Blindness Control, TB, Vector Borne Diseases, Leprosy Control, which do you think are **least effectively** implemented? Why?
5. What are some of the key programs implementation challenges / issues under the NRHM?
6. What are your priorities under the NRHM?
7. At the end of NRHM, what key differences/ changes do you think would have been made in the health status of (which) specific target groups?
8. NRHM covers all the national health programs. What kind of phasing or sequencing are you envisaging within the program?

### II. BCC Priorities

1. What do you understand by the term “behaviour change communication”? Does it have an important role in achieving the goals of NRHM? Tell me from a scale of 1 to 10 how important is BCC to achieving the goals of the NRHM? Why?
2. What are the existing BCC efforts in Uttar Pradesh? Can you tell me about them in detail? When did they start? To fulfil what objectives? Who was involved? Was there any impact? etc.
3. What are the weaknesses of existing BCC efforts in Uttar Pradesh?
4. What are the strengths of existing BCC efforts in Uttar Pradesh?
5. What is your vision of a BCC strategy for Uttar Pradesh?



- 
6. What is the scope of using mass media campaigns in UP? Please tell us your views in detail
  7. What is the scope of using community based BCC approaches such as home visits, group meetings, local structures such as Mahila mandals, youth groups etc? Please give us your views in detail.
  8.
    - a. What should the ASHA's role be in the overall BCC strategy for Uttar Pradesh?
    - b. We are proposing that the ASHA's be trained in very specific household level BCC. If she visits 8 households three times a week; she has the potential of reaching every eligible woman in her village 6 times a year. For 1.3 lakh ASHAs in UP, this means that 2.2 crore eligible women can be potentially reached. We are now talking about a much higher level of reach and frequency than electronic media. What do you think about the feasibility of this strategy?
    - c. Similarly, ANMs and medical officers can be trained in effective, behaviour focussed BCC. What do you think about the feasibility of this strategy?

### **III. Operational Issues**

1. What is the capacity in UP to train large number of ASHAs and ANMs in effective BCC? What can be done to ensure that there are enough trainers to build BCC capacity in ASHAs, ANMs and LHVs?
2. Do you agree that the common understanding of BCC at the district level is of "awareness creation" among villagers using media channels? Have you heard of the "knowledge-behaviour" gap? What does it mean?
3. What is the capacity in the State to develop effective district level BCC plans? What should be done to develop BCC planning skills at the district level?
4. What is the role of the IEC Bureau? How can it be strengthened?
5. What is the role of the district media officer? How much district level BCC planning is this officer involved in?
6. What is the training infrastructure you have for RCH? What capacity exists for micro planning for BCC services at the village/community level? What needs to be done to strengthen this capacity?
7. How do the district training teams function in UP? Do they exist in all districts?

### **IV Ensuring Implementation of the BCC Strategy Document**

1. Our country is well known for producing excellent policies on paper. What can be done to ensure that the BCC strategy document is implemented in UP as planned?
2. What institutional mechanisms would you suggest to review the progress of implementation of the BCC strategy for NRHM as it covers all the national health programs. What kind of phasing or sequencing are you envisaging to avoid overlap or too many media campaigns?
3. What are the regional variations in your state vis a vis RCH and other national programs. How would you like these variations addressed in the strategy document?
4. What have been the achievements of UP's BCC efforts so far?

---

## List of Core Group Members

**Chairperson:** Mr Rajeev Kapoor IAS, Mission Director NRHM & Executive Director SIFPSA

### Authors:

- Dr. Nandita Kapadia Kundu PhD, Consultant, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP), ITAP Project with
- Ms. Geetali Trivedi, Sr. Program Officer, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP), ITAP Project , Lucknow

### Core Group Members

1. Dr. Aruna Narain, Coordinator, Planning, Review, Monitoring, SPMU, NRHM
2. Dr. Brijendra Singh, Coordinator, FP, Clinical Trainings, BCC, SPMU, NRHM
3. Dr. M.K. Sinha, General Manager, Public Sector/IEC, SIFPSA
4. Dr. Ashok Misra, Coordinator, MCH & Adolescent Health, SPMU, NRHM
5. Dr Neera Jain, Director, SIHFW
6. Dr Jagdish Rai, Joint Director, National TB Programme, UP
7. Ms. Rashmi Singh, State Director, Mahila Samkhaya
8. Dr Shalini Raman Dy. Director IEC, UPSACS
9. Dr. Vishwajeet Kumar, Director & Associate Faculty JHSPH
10. Ms. Rachna Sharma, Programme Communication Officer, UNICEF
11. Representative, PATH

### List of Reviewers:

Upon completion, the strategy document has been reviewed by the following:

1. Ms. Kendra Phillips, Deputy Director PHN,USAID
2. Ms. Sheena Chabra, Health Systems Division Chief, USAID
3. Ms. Moni Sinha Sagar, BCC & Marketing Advisor, USAID
4. Dr. Lovleen Johri, Sr. Reproductive Health Advisor, USAID
5. Ms. Beth Fisher, Sr. Technical Advisor, Vistaar Project
6. Mr. Laxmikant Palo, Technical Advisor, Vistaar Project
7. Ms. Shuvi Sharma, ITAP
8. Dr. Neill Mckee, Regional Director Asia, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP)
9. Ms. Shailaja Maru, Program Officer, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP)

## Annexure 4

### District Level Infant Mortality Estimates for Uttar Pradesh (2001 Census Data)

Infant Mortality Rate	Districts	Number of Districts
<b>Less than 50 per 1000 live births</b>	Kanpur Nagar (38), Ballia (35)	2
<b>50-70 per 1000 live births</b>	Meerut (64), Baghpat (60), Ghaziabad (55), Bulandshahr (69), Mathura (70), Gautam Buddha Nagar (67), Agra (65), Lucknow (66), Faizabad (70), Gorakhpur (59), Kushinagar (69), Mau (58), Ghazipur (59)	13
<b>71-80 per 1000 live births</b>	Saharanpur (74), Muzaffarnagar (75), Bijnor (72), Moradabad (73), Jyotiba phule nagar (77), Mainpuri (78), Khorī (76), Auraiya (79), Kanpur Dehat (80), Hamipur (79), Ambedkar Nagar (74), Basti (77), Deoria (75), Jaunpur (79), Chandauli (74), Varanasi (72), Etawah (80)	17
<b>81-90 per 1000 live births</b>	Aligarh (87), Firozabad (87), Bareilly (81), Farrukhabad (86), Kannauj (82), Jalaun (86), Jhansi (82), Mahoba (88), Banda (86), Fatehpur (89), Pratapgarh (84), Barabanki (87), Sant Kabir Nagar (83), Azamgarh (81), Mirzapur (82), Sonbhadra (82)	16
<b>91-100 per 1000 live births</b>	Rampur (95), Hathras (93), Pilibhit (94), Shahjahanpur (100), Sitapur (97), Unnao (91), Rae Bareilly (91), Lalitpur (99), Chitrakoot (94), Kaushambi (94), Allahabad (100), Sultanpur (92), Baharaich (99), Shrawasti (95), Gonda (92), Siddharthnagar (92), Maharajganj (99), Sant Ravidas Nagar Bhadoni (96)	18
<b>Above 100 per 1000 live births</b>	Etah (104), Budaun (110), Hardoi (106), Balrampur (107)	4
<b>Total</b>		70

## Annexure 5

### NRHM Trigger Behaviours Total NRHM Health Areas - 10; Prioritized Behaviours: 28

<b>1. Women's Health</b>	<b>Anaemia</b>	Eat 3 times a day
		Eat iron rich and vitamin C food daily
<b>2. Maternal Health</b>	<b>Ante Natal Care</b>	Early registration <12 weeks
		3 ANC check ups
	<b>Intra Natal Care</b>	Institutional Delivery
	<b>Post Natal Care (Mother)</b>	Stay in the hospital for 24 hrs after delivery
		Get at least one PNC at home or at service facility immediately or latest within 1 week
		Care seeking for danger signs
		Eat 4 times a day
<b>3. Newborn Health</b>	<b>New Born</b>	Immediate and exclusive Breast feeding within 1 hr
		Don't apply anything to the cord
		Keep the baby warm; Weigh newborn within 24 hrs
<b>4. Child Health</b>	<b>Infant / Child &lt;5 yrs</b>	Exclusive Breast feeding for 6 months
		Complete Immunization/ Booster / Vit A
		Complementary feeding from 6 months 4-5 times in addition to breast feeding
<b>5. Family Planning</b>	<b>Spacing</b>	Delay the first pregnancy
		Increase birth interval to 3 years
	<b>Limiting</b>	Adopt any limiting method after 2 children even if both are girls
<b>6. TB</b>		Early identification of TB
		Continue and complete treatment for prescribed period
<b>7. Vector Borne</b>	<b>Malaria / JE</b>	Get blood tested for Malaria if suffering from fever
		Empty and dry water containers for 1 day in a week
		Remove piggeries from residential areas
		Inform VHSC/ASHA/ANM about outbreak
<b>8. Leprosy</b>		Early identification & treatment of Leprosy
<b>9. Blindness Control</b>		Seek care if vision is unclear
<b>10. Adolescent Health</b>		Age at marriage, IFA supplementation
<b>11. Hygiene &amp; Sanitation</b>		Hand washing after defecation and before feeding child

## Annexure 6: Modified BCC Log Frame 1: Maternal and Newborn Health

Overall Objective: To reduce maternal mortality in Uttar Pradesh from 517 per lakh live births to less than 360 per lakh live births by 2010<sup>42</sup>

Behavioural Objectives				
To increase early registration (< 12 weeks) from 25.7 percent to 50 percent by 2010 <sup>43</sup>				
To increase 3 ANC check ups from 26.3 to 50 percent by 2010 <sup>2</sup>				
Socio-Cultural Barriers, Health Service Barriers				
Barriers (Col 1)	Interventions (Col 2)	Strategy (Col 3)	Activities (Col 4)	Monitoring Indicators (Col 6)
<ul style="list-style-type: none"> <li>Lack of social norm of early registration</li> <li>Added expenses in terms of fees, medicines and transport.</li> <li>Belief that getting womb examined by a woman of lower caste would lead to a bad omen.</li> <li>Lack of perceived need as previous deliveries were normal without having ANC check ups<sup>44</sup></li> <li>Gender: Low autonomy and status of women in Uttar Pradesh<sup>45</sup></li> </ul>	<p><b>State Level: (Mass Media Channels)</b></p> <ul style="list-style-type: none"> <li>Audiovisual spots on               <ul style="list-style-type: none"> <li>TV</li> <li>Local Cable TV. Daily spots during 4 months</li> <li>Short films "CD Spots" on specific issues</li> </ul> </li> <li>Radio spots minimum of 3-4 spots a day on Primary Channels &amp; FM</li> </ul> <p><b>Community Level: (Counselling / Group Meetings)</b></p> <ul style="list-style-type: none"> <li>2 meetings on ANC in a year – one by ASHA and one by ANM</li> <li>VHND or <i>Khushali</i> Diwas               <ul style="list-style-type: none"> <li>ANC service provision during VHND</li> <li>TV Spot / Audio visual spots / Posters for VHND</li> </ul> </li> </ul>	<p><b>Strategy 1a:</b></p> <ul style="list-style-type: none"> <li>Focus on the concept of "punya" (spiritual merit)<sup>46</sup> to the family, <i>pradhans</i> and providers if maternal and newborn lives are to be saved. Specific actions to be promoted               <ul style="list-style-type: none"> <li>Early registration</li> <li>3 Ante Natal Checkups</li> </ul> </li> </ul> <p><b>Strategy 1b:</b></p> <ul style="list-style-type: none"> <li>Promote male responsibility for early registration and 3 ANC visits.</li> </ul>	<ul style="list-style-type: none"> <li>Development &amp; Production of campaign materials like TV, Radio, audio visual films, Local media &amp; Print materials like Posters, Wall Painting, Hoardings, IPC tools.</li> <li>Preparation of Guidelines &amp; IPC tools on MNH for home visits &amp; Group Meetings by ASHAs</li> <li>Listing of eligible women for Home visits &amp; Group meetings</li> </ul>	<ul style="list-style-type: none"> <li>No. of times TV spots aired/ No of times planned x 100</li> <li>No. of times Radio spots aired/ No of time planned x 100</li> <li>No. of group meetings held/No of group meetings planned x 100</li> <li>No. of HH visits conducted /No of HH Visits planned x 100</li> <li>No. of VHNDs held/No. of VHNDs planned x 100</li> </ul>
<b>Lack of access to resources including</b>	<b>Household Level: (Using Interpersonal</b>	<b>Strategy 1c:</b> Promote VHND ( <i>Khushali</i> )	Community activities like rallies by children; Poster	No. of Community events for <i>Khushali</i> Diwas held /No. of

<sup>42</sup> Uttar Pradesh NRHM PIP (2008)

<sup>43</sup> Uttar Pradesh NRHM PIP (2008)

<sup>44</sup> V. Sethi et al. (2005) "Contextual Factors Influencing Newborn Care amongst the Rural Poor in Western Uttar Pradesh" Pakistan Journal of Nutrition 4 (4) 273-275

<sup>45</sup> K. Gupta and Yesudian, P. P. (2006) "Evidence of Women's Empowerment in India: A study of Socio-Spatial Disparities" Journal of Geo-Social Studies 65: pp 365-380

<sup>46</sup> "The Household Dimension of the Family in India" A. M. Shah. University of California Press. 1974

<b>information on ANC</b>	<b>Communication)</b> Home visits by ASHA to pregnant women twice a week x 3 home visits <sup>47</sup>	<b>Diwas</b> as a day where ANC services are available at the village level and increase demand by participation in village level community events. <b>Strategy 2a:</b> <ul style="list-style-type: none"><li>Utilize new resources like the ASHA for Home Visits and Group Meetings</li></ul> <b>Strategy 2b:</b> <ul style="list-style-type: none"><li>Provide ANC services and counselling services at the village level</li></ul>	competitions; Quiz; games on VHND <ul style="list-style-type: none"><li>Develop IPC fo Home visits for ASHA</li><li>Digitise existing ABK flipbook into an audio visual counselling tool</li></ul>	Community events for <i>Khushali Diwas</i> planned x 100
<b>No trust in govt health system; services not available</b> <sup>48</sup> <ul style="list-style-type: none"><li>Infrequent visits by ANM</li><li>Involvement of ANM in other vertical programs</li></ul>	<b>Service Provider Level: (Capacity building / Policy Initiatives)</b> <ul style="list-style-type: none"><li>Regular ANC services by ANM at village level</li><li>Supportive Supervision &amp; Community Monitoring</li><li>IPC / Counselling skills Training to improve comm. Skills of ANM</li></ul>	<b>Strategy 3a:</b> <ul style="list-style-type: none"><li>Service Provider Motivational Campaign promoting quality of care</li></ul> <b>Strategy 3b:</b> <ul style="list-style-type: none"><li>Communication skills training</li><li>LHV/HEO training in supportive supervision</li></ul> <b>Strategy 3c:</b> <ul style="list-style-type: none"><li>Increased Community Interaction &amp; Accountability</li></ul>	Develop and Link campaign to quality of care related to specific care seeking behaviours <ul style="list-style-type: none"><li>Village Health &amp; Sanitation Committees to plan Assessment of ANMs</li><li>Felicitation of Service Providers at VHND <i>Khushali Diwas</i> and ASHA Diwas</li><li>Development of IPC module for training</li><li>Development of Module for supportive supervision</li></ul>	<ul style="list-style-type: none"><li>No. of Service Providers trained/ No of Service Providers trainings planned x 100</li><li>Number of Service Providers felicitated / No of planned x 100</li></ul>

<sup>47</sup> "Home and community based interventions involving health extension or community health workers have a substantial impact on neonatal mortality including mortality in the first week of life". Expert Consultation on Community Based Approaches for Neonatal Sepsis Management, London, Sept 26-28, 2007. pp 29

<sup>48</sup> N. Chaudhary, J. Hammer et al (2006) "Missing in Action: Teacher and Health Worker Absence in Developing Countries" Journal of Economic Perspectives, Vol 20, No 1, Winter, pp 91-116

## Modified BCC Log Frame 2 Institutional Delivery and Hospital Stay of 24 hours

Overall Objective: To reduce maternal mortality in Uttar Pradesh from 517 per lakh live births to less than 360 per lakh live births by 2010<sup>49</sup>

Behavioural Objectives					
1. To increase institutional deliveries from 22percent to 50 percent by 2010 <sup>2</sup>					
2. To ensure that the woman is in the hospital 24 hours after delivery to enable early breastfeeding; BCG and BCC on post natal care					
Socio-cultural /Health Services/Other					
Barriers (Col 1)	Interventions (Col 2)	Strategy (Col 3)	Activities (Col 4)	Workload (Col 5)	Monitoring Indicators (Col 6)
<ul style="list-style-type: none"> <li>Home delivery: generations old practice</li> <li>Services not available at village level<sup>44</sup></li> <li>Birth preparedness taboo (bad luck)<sup>50</sup></li> </ul>	<p><b>State Level: (Mass Media /Print / Local Media)</b></p> <ul style="list-style-type: none"> <li>Audiovisual spots on JSY, Transportation arrangements by VHSC               <ul style="list-style-type: none"> <li>TV / Local Cable TV. Daily spots during 4 months</li> <li>Short films "CD Spots" on JSY and benefits of institutional deliveries</li> </ul> </li> <li>Radio spots minimum of 3-4 spots a day on Primary Channels &amp; FM</li> <li>Bus Panels / Posters</li> <li>Wall Paintings at the village level</li> <li>Community notice boards</li> <li>Hoardings at service sites</li> </ul>	<p><b>Strategy 1:</b></p> <ul style="list-style-type: none"> <li>Create awareness about community entitlement for Janani Suraksha Yojna (JSY)</li> </ul> <p><b>Strategy 2:</b></p> <ul style="list-style-type: none"> <li>Promote the concept of registration by the family members at the Hospital in the 9th month as a part of the birth preparedness plan</li> </ul>	<ul style="list-style-type: none"> <li>Development &amp; Production of campaign materials like TV, Radio, audio visual films, Local media &amp; Print materials like Posters, Wall Painting, Hoardings</li> <li>TV spot on responsibility of VHSC to arrange for transport for institutional delivery</li> <li>Birth planning to be included in IPC tool</li> </ul>	<ul style="list-style-type: none"> <li>1 Birth Planning Home Visit x 30 pregnant women = 30 home visits per ASHA per year</li> <li>Meetings of village Health &amp; Sanitation Committee x 130,000 committees</li> </ul>	<ul style="list-style-type: none"> <li>No of deliveries at the hospitals/Total no of deliveries x100 (Annual)</li> <li>No of committees arranged transport/Total no of committees x 100</li> </ul>

<sup>49</sup> Uttar Pradesh NRHM PIP (2008)

<sup>50</sup> Kumar, V. Mohanty, S. et al 2008 (submitted) "Impact of Community based Behaviour Management on Neonatal Mortality: a cluster, randomized control trial in Shivgarh, Uttar Pradesh"

<ul style="list-style-type: none"> <li>▪ Services not available near by</li> <li>▪ Emergency transport not available</li> <li>▪ Emergency cases are referred to private midwives (retired ANM/ LHV's ) as they are a trusted source<sup>44</sup></li> </ul>	<p><b>Community Level: (IPC / Group Meetings/ VHSC Meetings)</b></p> <ul style="list-style-type: none"> <li>▪ Group Meeting on birth planning</li> <li>▪ Village Health &amp; Sanitation Committee to arrange transportation to facilitate institutional deliveries</li> <li>▪ Transport arrangements for obstetric emergencies</li> </ul> <p><b>Household Level: (Interpersonal Communication)</b></p> <ul style="list-style-type: none"> <li>▪ Home Visits by ASHA (3rd ANC visit ) to promote:             <ul style="list-style-type: none"> <li>○ Birth preparedness</li> <li>○ Birth planning<sup>47</sup></li> <li>○ Identification of High risk pregnancies</li> </ul> </li> </ul>	<p><b>Strategy 3:</b></p> <ul style="list-style-type: none"> <li>▪ Responsibility of organizing transportation for the delivery and for obstetric emergencies</li> </ul>		
<p>In case of home delivery, promote the following<sup>Error! Bookmark not defined.</sup>:</p> <ol style="list-style-type: none"> <li>1. Ventilation and cleaning of the "saur" ; not to apply fresh cow dung or clay on the floor of the "saur" before the delivery.</li> <li>2. Birth attendant should wash her hands with soap prior to the delivery</li> <li>3. New blade</li> <li>4. Boiled "cord tie"</li> <li>5. Assign roles to birth attendant and assistants</li> </ol>				



### Modified BCC Log Frame 3: Newborn Care -- To reduce IMR from 71 per 1000 live births to less than 45 per live births by 2010<sup>42</sup>

Behavioural Objectives				
<b>1. Immediate breastfeeding within 1 hour of birth from 7.2 percent to 25 percent by 2010</b> <b>2. Don't apply anything to the cord</b> <b>3. Keep the baby warm with skin-to-skin care and wrapping the baby with a cotton cloth</b> <b>4. Weigh newborn within 24 hours from ---- to ---- percent in 2010</b>				
Barriers (Col 1)	Interventions (Col 2)	Strategy (Col 3)	Activities (Col 4)	Monitoring Indicators (Col 6)
<ul style="list-style-type: none"> <li>▪ Fear that baby would be harmed if traditions not followed<sup>44</sup></li> <li>▪ No reason to discontinue existing practices</li> <li>▪ Reason for prelacteal feeds:               <ul style="list-style-type: none"> <li>○ Local belief that mother's milk cannot quench baby's thirst</li> <li>○ "gutti" given for bowel movement</li> <li>○ Colostrum is polluting<sup>51</sup></li> <li>○ Mother's milk flows only after "nahan ceremony"</li> <li>○ Weighing newborn within</li> </ul> </li> </ul>	<p><b>State Level: (Mass Media / Print / Local Media)</b></p> <ul style="list-style-type: none"> <li>▪ Audiovisual spots on colostrum &amp; exclusive breast feeding               <ul style="list-style-type: none"> <li>○ TV / Local Cable TV. Daily spots during 4 months</li> <li>○ Short films "CD Spots" on BF and NBC</li> </ul> </li> <li>▪ Radio spots minimum of 3-4 spots a day on Primary Channels &amp; FM</li> <li>▪ Posters at Maternity wards promoting BF, NBC (No bath for a week, No prelacteal feeds, Skin to skin care, Keeping cord stump dry,</li> <li>▪ Explore tie-ups with baby products manufacturers like J&amp;J for BF messages on baby soaps, oils, matchboxes etc.</li> </ul> <p><b>Community Level: (IPC/Counselling / Group Meetings VHSC Meetings)</b></p> <ul style="list-style-type: none"> <li>▪ Group Meeting by ANM/ ASHA on Newborn Care</li> <li>▪ Group Meeting by ANM/ ASHA on Institutional Deliveries</li> </ul>	<p><b>Strategy 1:</b></p> <ul style="list-style-type: none"> <li>▪ Promote immediate and exclusive breast-feeding within 1 hour of birth.</li> </ul> <p><b>Strategy 2:</b></p> <ul style="list-style-type: none"> <li>▪ Utilize opportunity created by JSY to increase knowledge of NBC by counselling of parents of newborns.</li> </ul> <p><b>Strategy 3:</b></p> <ul style="list-style-type: none"> <li>▪ Use 2 PNC home visits by ASHA within 48 hours and within 3-7 days of delivery for PNC and NBC health monitoring</li> </ul>	<ul style="list-style-type: none"> <li>▪ Development &amp; Production of campaign materials like TV, Radio, audio visual films, Local media &amp; Print materials like leaflets, NBC cards, Posters, Wall Painting, Hoardings adapting socio-culturally relevant BCC inputs from Shivgarh project</li> <li>▪ IPC tool on essential new born care</li> <li>▪ Badhai (MNH) Kit to be given to parents of newborn with baby card (monitoring of birth weight, immunization schedule, New born care, Condoms) at discharge from hospital in case of JSY or by ASHA in case of home delivery</li> <li>▪ Presence of trained</li> </ul>	<ul style="list-style-type: none"> <li>▪ No of newborns exclusive BF within 1 hour of birth/Total no of newborns x 100</li> <li>▪ No of newborns weighed within 24 hrs/Total no of newborns x 100</li> <li>▪ No of newborns wrapped in soft cotton cloth/Total newborn x 100</li> <li>▪ No of newborns given skin to skin care/Total no of newborns x 100</li> </ul>

<sup>51</sup> Reissland, N. and Burghart, R. (1988) "The Quality of a Mother's Milk and the Health of her Child: Beliefs and Practices of the Women in Mithila". Social Science and Medicine, vol 27, No 5, pp 461-469

<sup>52</sup> The number of mothers and new borns are calculated at an estimated Crude Birth Rate (CBR) of 30 per 1000. Thus for 1,30,000 ASHA areas (of about 1000 population each) there would be about 39,000,00 (39 lakh) mothers and new borns in one year.

24 hours is not feasible during home deliveries; is a new practice	<p><b>Household Level: (Using Interpersonal Communication)</b></p> <ul style="list-style-type: none"> <li>▪ Home deliveries: home visit for newborn care by ASHA within 48 hours</li> </ul> <p><b>Service Provider Level: (Capacity building / Policy Initiatives)</b></p> <ul style="list-style-type: none"> <li>▪ 2 PNC Home visits by ASHA and at least 1 PNC visit by ANM (within 48 hours and from 3-7 days)<sup>47</sup></li> <li>▪ Linkages with AWW to weigh newborns in case of home deliveries</li> <li>▪ BCC about new born care to be provided to mother &amp; relatives at facility</li> <li>▪ Newborns must be weighed at the institution</li> </ul>			counsellors at FRUs for counselling of parents on NBC and post partum FP.	
--	--	--	--	---	--

## Modified BCC Log Frame 4: Family Planning

Overall Objective: To reduce TFR from 3.8 to 2.60 by 2010<sup>42</sup>

Behavioural Objectives To delay first pregnancy by 1 year on average in couples where the wife is a married adolescent <sup>53</sup> To have an interval of 3 years between 2 births To adopt a limiting method after 2 children even if both are girls				
Barriers (Col 1)	Interventions (Col 2)	Strategy (Col 3)	Activities (Col 4)	Workload (Col 5)
<ul style="list-style-type: none"> <li>Norm of proving fertility within one year of marriage</li> <li>Lack of contraceptive options for newly weds</li> <li>Limited outreach services in terms of frequency &amp; regularity<sup>54</sup></li> <li>Lack of quality of care<sup>14</sup></li> <li>Son preference<sup>56</sup></li> </ul>	<p><b>State Level: (Mass Media / Print / Local Media)</b></p> <ul style="list-style-type: none"> <li>Special focus on married adolescents</li> <li>Link to spiritual merit gender equity for pradhan, community leaders</li> <li>Identify couples with 2 girls</li> </ul> <p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>Group meetings</li> <li>Couple counselling</li> </ul> <p><b>Household Level (Using Interpersonal Communication)</b></p> <ul style="list-style-type: none"> <li>Home visits to promote temporary methods</li> </ul> <p><b>Service Provider Level: (Capacity building / Policy Initiatives)</b></p> <ul style="list-style-type: none"> <li>Motivational Campaign for ANM/MPW. "spiritual merit" approach.</li> <li>Linkages with RMP in village Campaign</li> </ul>	<p><b>Strategy 1</b></p> <ul style="list-style-type: none"> <li>Campaign to run during wedding seasons</li> <li>TV; radio; bill boards; wall paintings on services at sub centre and PHC levels</li> </ul> <p><b>Strategy 2</b></p> <ul style="list-style-type: none"> <li>Six home visits per year to married adolescents by ASHA</li> <li>Three home visits per year to husbands of married adolescents by male worker.</li> </ul> <p><b>Strategy 3</b></p> <ul style="list-style-type: none"> <li>Community monitoring of worker absenteeism</li> </ul> <p><b>Strategy 4</b></p> <ul style="list-style-type: none"> <li>Involve males, village elders; Promote limiting methods; provide quality services</li> </ul>	<ul style="list-style-type: none"> <li>VHND – felicitation of couples who have delayed first birth by 12 months</li> <li>TV Radio spots</li> <li>Use of satisfied beneficiary</li> <li>Prep of campaign materials;</li> <li>Monitoring of ANM visits</li> <li>Developing RMP for providing spacing methods</li> <li>TV Spots</li> <li>Village Health Committee monitoring</li> </ul>	<p><b>Monitoring Indicators</b></p> <ul style="list-style-type: none"> <li>No of newly wed couples using contraceptives in first year of marriage/total newly weds</li> <li>No of couples using contraceptives for spacing between children/ No of eligible couples</li> <li>No of ANMs/MPWs exposed to campaign/</li> <li>Total ANM/MPWs x 100</li> <li>No of couples adopting Terminal methods/No of couples with 2+ children x 100</li> </ul>

<sup>13</sup> About 61 percent women (20-24 yrs) were married prior to 18 years in rural Uttar Pradesh (NFHS -3). As a result if there are 150 eligible couples in a rural population of 1000, then 90 married women are in the adolescent category . Koenig, M., Foo, G., Joshi K. (2000)

<sup>54</sup> "Quality of Care Within the Indian Family Welfare Programme: A Review of Recent Evidence". Studies in Family Planning, vol 31, No 1, pp 1-18; Uttar Pradesh had among the lowest outreach coverages by ANM and MPW.

## Modified BCC Log Frame 5: Nutrition of Adolescents and Women (adolescent girls, married women, pregnant women)

Overall Objective: To reduce maternal mortality in Uttar Pradesh from 517 per lakh live births to less than 360 per lakh live births by 2010<sup>55</sup>

Behavioural Objectives					
1.Adolescent girls to eat 3 times a day in food secure HHs 2. Women to eat 3 times a day in food secure HHs 3. Pregnant and lactating women to eat 3-4 times a day in food secure HHs 4. Pregnant and lactating women to eat an iron rich and vitamin C rich food daily in food secure HHs 5. Linkages with anganwadi for supplementary meal for pregnant and lactating especially for women in HHs with no food security					
Barriers	Interventions	Strategy	Activities	Workload	Monitoring Indicators
<ul style="list-style-type: none"><li>Eating pattern of twice a day</li><li>Women eat last</li><li>Food restrictions during pregnancy<sup>56</sup></li><li>Belief that baby will not grow if woman eats too much during pregnancy</li><li>Poverty; issue of food security of the household</li></ul>	<p><b>State Level: (Mass Media / Print / Local Media)</b></p> <ul style="list-style-type: none"><li>Campaign theme</li></ul> <p><b>Community Level</b></p> <ul style="list-style-type: none"><li>Group meeting twice a year</li></ul> <p><b>Household Level (Using Interpersonal Communication)</b></p> <ul style="list-style-type: none"><li>Home Visits to all eligible women</li><li>Adolescents reached through AWW</li><li>3 home visits to pregnant women to 2 to lactating women</li></ul> <p><b>School Level</b></p> <ul style="list-style-type: none"><li>An in-school anaemia prevention programme for girls 9-14 years</li></ul>	<p><b>Strategy 1 a.</b></p> <p>For food secure HHs:</p> <ul style="list-style-type: none"><li>Assess eating, cooking patterns of the household</li><li>Assess woman's current dietary intake; Provide need based, practical solutions</li><li>Refer to meal plan</li></ul> <p><b>Strategy 1 b.</b></p> <p>For HHs without food security</p> <ul style="list-style-type: none"><li>Prepare list of such HHs</li><li>Make linkages with anganwadi</li><li>Make linkages with village samiti</li></ul> <p><b>Strategy 2</b></p> <p>Girl-to-family nutrition education</p> <ul style="list-style-type: none"><li>Recipe Competitions</li><li>Cook book demonstration</li><li>Bring an iron rich food for every meeting</li><li>3 months IFA supplement</li></ul>	<ul style="list-style-type: none"><li>Adapt IPC tool for nutrition to assess dietary needs</li><li>Build capacity of ASHA to use tool</li><li>&amp; do follow ups</li><li>Adapt IHMP cookbook for Uttar Pradesh</li><li>Prepare a plan</li><li>Enrol schools</li><li>Get IFA stock</li><li>Promote introduction of daily snack</li></ul>	<ul style="list-style-type: none"><li>2 Home Visits a year x 150 women/ASHA area = 300 visits per year/ASHA = 25 visits per month = 25 x 130000 =</li><li>1 group meeting on nutrition x 1,30,000 ASHA = 1,30,000 mtgs</li><li>1 group meeting by ANM x 1,30,000 ASHA areas</li><li>10 schools/district /x 70 districts = 700 schools</li></ul>	<ul style="list-style-type: none"><li>No. women eating 3 times a day/total women x 100</li><li>No of pregnant women eating 3-4 times a day/total pregnant women x 100</li><li>No of adolescent girls eating 3 times a day/total no of adolescent girls</li><li>No of pregnant women from marginalized</li><li>HHs receiving food supplement from anganwadi/ total pregnant women from marg. HHs</li><li>No. of girls (9-14 yrs) eating iron rich food daily/total no of girls</li></ul>

<sup>55</sup> Uttar Pradesh NRHM PIP (2008)

<sup>56</sup> Kumar, A. and Das, M. (2008) "Towards Equity in Health: A Study of Barriers in Accessing RCH Services in Uttar Pradesh", ITAP, Futures Group International

## Modified BCC Log Frame 6: Child Health

**Overall Objectives:** Reduction in infant mortality rate from 72 per 1000 live births to less than 30 per 1000 live births by 2010; Reduction in underweight children under 3 years from 47.3 to 35 by 2010

Behavioural Objectives				
1. To increase percent of infants receiving complementary feeds from six months from 45.5 percent to 60 percent <sup>57</sup> 2. To promote hygiene habits such as hand washing with soap after defecation, before feeding child and after disposing child's stools <sup>58</sup> 3. To promote ORS and referral for ARI in children under three years				
Barriers	Interventions	Strategy	Activities	Workload
<ul style="list-style-type: none"> <li>Lack of social norm of giving complement-ary feed at six months</li> <li>Frequency of comp. feeds coincides with adult eating patterns</li> <li>Late health seeking behaviours for diarrhoea and ARI</li> <li>Lack of habit:- hand washing with soap.</li> <li>In houses with no food security – lack of resources for comp feeds etc.</li> <li>Discrimination against the girl child</li> </ul>	<b>State Level: (Mass Media /Print / Local Media)</b> <ul style="list-style-type: none"> <li>TV spots on complementary foods at six months</li> <li>TV/Radio/CD Spots</li> </ul> <b>Community Level/ HH Level</b> <ul style="list-style-type: none"> <li>Community based interventions such as group meetings and home visits<sup>58</sup></li> <li>One group meeting on child health; six home visits a year by ASHA with mothers of under three children</li> <li>Identify HH with low food security; Samiti to be given responsibility</li> </ul>	<b>Strategy 1</b> <ul style="list-style-type: none"> <li>BCC and follow up by ASHA on compl. feeds at six months;</li> <li>BCC on diarrhoea and ARI management in children u-3 yrs through home visits</li> </ul> <b>Strategy 2</b> <ul style="list-style-type: none"> <li>TV spot should emphasize the frequency of top feeds in addition to breastfeeding</li> <li>TV spot on hand washing with soap</li> <li>Linkages with AWW; promote low cost foods</li> </ul> <b>Strategy 3</b> <ul style="list-style-type: none"> <li>Promote value of girl child ; show data on how more girls (U-5) are dying in Uttar Pradesh than boys; list things that can be done to reduce discrimination</li> </ul>	<ul style="list-style-type: none"> <li>Prepare a list of under three children in the village</li> <li>Prepare simple IPC tool for ASHA</li> <li>Children to promote hand washing with soap</li> <li>Mobilize community resources for poor families</li> <li>Prepare script</li> <li>Launch campaign according to campaign theme</li> </ul>	<ul style="list-style-type: none"> <li>Home visit ASHA x 30 infants/a year = 2-3 six month olds a month</li> <li>Grp meeting x 1,30,000 ASHAs = 1,30,000 mtgs</li> <li>20 children/village x 10 HHs = 200 HHs/village</li> <li>Committee to monitor needs of 10-15 HHs</li> <li>Preparation of TV/Radio/ CD spots</li> </ul>
				<b>Monitoring Indicators</b> <ul style="list-style-type: none"> <li>No of infants comp feeding at six months/No. of infants x 100</li> <li>No of mothers u-3 yrs hand washing with soap/Total mothers of u-3yrs x 100</li> <li>No of Marg HHs assisted/Tot no of marg HHs x 100</li> <li>Percent girls given compl feeds by six months vs</li> <li>Percent boys given compl feeds by six months</li> </ul>

<sup>57</sup> There is sufficient evidence for the following interventions for child under nutrition and survival –BCC for improved complementary feeding; hand washing or hygiene interventions. Bhutta, Z. A. et al (2008) “Maternal and Child Under nutrition 3 What works? Interventions for Maternal and Child Under nutrition and Survival” Lancet, vol 371 pp 417-440

<sup>58</sup> Haines et al (2007) “Achieving Child Survival Goals: Potential Contribution of Community Health Workers” Lancet vol 369 pp 2121-2131. They quote a study that estimates that a total of 18 contacts with mother and child over five years ( 3 per year) can “deliver effective child survival interventions, almost entirely through community based and outreach delivery efforts” pp 2123

## Modified BCC Log Frame 7: Routine Immunization

Behavioural Objectives To increase percent of children (12-23 months) fully immunized from 22.9 percent to 50 percent				
Barriers to RI	Interventions	Strategy	Activities	Workload
<ul style="list-style-type: none"> <li>Community ownership lacking<sup>59</sup></li> <li>Less than 30 percent planned RI sessions held due to other activities<sup>59</sup></li> <li>BCC prog weak at all levels<sup>20</sup></li> <li>Lack of quality services<sup>20</sup></li> <li>Negative Impact of Pulse Polio campaign on RI<sup>20</sup></li> </ul>	<p><b>State Level: (Mass Media /Print / Local Media)</b></p> <ul style="list-style-type: none"> <li>Colour coded 5 contact TV/Radio/CD Spots</li> </ul> <p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>Village Health &amp; Sanitation Committee</li> <li>VHND</li> <li>Integrated RI Campaign</li> <li>Special outreach sessions for urban slums</li> </ul> <p><b>Household Level</b></p> <ul style="list-style-type: none"> <li>Home visit by Bal Chetaks</li> </ul>	<p><b>Strategy 1</b></p> <ul style="list-style-type: none"> <li>Colour coded RI Strategy Time, Day Place posted at all prominent places in village</li> <li>Campaign</li> </ul> <p><b>Strategy 2</b></p> <ul style="list-style-type: none"> <li>TV Radio Spots focussing on number of contacts in a year;</li> <li>TV/ radio spots on VHND &amp; community monitoring of VHND</li> <li>TV /radio spots with a tele complaint number if VHND not held</li> </ul> <p><b>Strategy 3</b></p> <ul style="list-style-type: none"> <li>Bal Chetak Strategy</li> </ul>	<ul style="list-style-type: none"> <li>Community notice board</li> <li>Posters with details of RI sessions</li> <li>Posters with NUMBER of contacts in a year</li> <li>School children (12-14 yrs) to monitor immun coverage of infants in 10 neighbouring HHs (Shiksha mitra to organise); Immun schedule to given to school children</li> <li>Immun card shld have seasonal calendar (pictorially) so mother can recognize when baby should be brought for measles vaccine</li> </ul>	<ul style="list-style-type: none"> <li>Comm notice boards in place</li> <li>Develop and print new posters</li> <li>Select 5-6 school children and assign them to 5 infants in their area</li> <li>Provide the children with formats so that they can fill in the immune record of each child under their supervision</li> </ul>
				<p><b>Monitoring Indicators</b></p> <ul style="list-style-type: none"> <li>Notice Boards with RI Posters/Exp notice boards x 100</li> <li>No. of VHNDs held/VHNDs planned x 100</li> <li>No. of tele complaints received</li> <li>No of infants fully immunized/Total infants x 100</li> </ul>

<sup>59</sup> The barriers for the routine immunization programme have been taken from a report by a WHO led State Review in Uttar Pradesh in 2004. "Universal Immunization Programme Review. Aug 25 to Sept 8, 2004." [http://www.whoindia.org/LinkFiles/Routine\\_Immunization\\_UP.pdf](http://www.whoindia.org/LinkFiles/Routine_Immunization_UP.pdf); accessed Aug 11,2008.

Also it is important to note is that except for polio coverage, the coverage for other vaccines have barely gone up in Uttar Pradesh between the NFHS2 and NFHS3 surveys.

### Modified BCC Log Frame 8: RNTCP (Revised National Tuberculosis Control Programme)

Overall Objective: To achieve and maintain cure rate of at least 85 percent among newly detected infections (new sputum positive cases)

Behavioural Objectives To achieve and maintain detection of atleast 70 percent of cases <sup>60</sup> To ensure complete treatment					
Barriers	Interventions	BCC Strategy	Activities	Workload	Monitoring Indicators
<ul style="list-style-type: none"> <li>TB suspects not being referred to DMCs from PHIs as per indicator (2-3 % OPD)</li> <li>Untrained DTOs and MOTCs because of frequent transfers</li> <li>Medical colleges can increase coverage</li> <li>Lack of supervision at district level</li> <li>Lack of knowledge in urban slums</li> <li>Private practitioners not involved</li> </ul>	<p><b>State Level: (Mass Media /Print / Local Media)</b></p> <ul style="list-style-type: none"> <li>TB Week, Wall Writings, Outdoor Displays, FM Radio, TV etc.</li> </ul> <p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>To improve case detection</li> <li>Strengthen DOT network</li> </ul> <p><b>Provider/Policy Level</b></p> <ul style="list-style-type: none"> <li>17 high priority districts for supervision and monitoring identified</li> </ul>	<ul style="list-style-type: none"> <li>One week campaign during Anti TB Day (Feb 24th)</li> <li>Community Meetings for slums/SC dominated/ densely populated areas etc.</li> <li>IPC training</li> <li>Micro planning for urban areas</li> <li>Strengthen linkages with pvt practitioners and medical colleges</li> </ul>	<p>Campaign to include</p> <ul style="list-style-type: none"> <li>TV; radio spots</li> <li>State &amp; district level events to felicitate DOTS volunteers</li> <li>Hoardings/wall paintings</li> <li>School based BCC activities</li> <li>(Broadcast a special programme to school children during that week); Plan essay competition</li> </ul>	<ul style="list-style-type: none"> <li>Prep of TV, radio spots</li> <li>Organizing District level events x 70 districts</li> <li>Organizing State level events</li> <li>Broadcast special programme to school children</li> </ul>	<ul style="list-style-type: none"> <li>New Cases/Exp Cases x 100</li> <li>Cases with complete treatment/Total cases x 100</li> </ul>

<sup>60</sup> The log frame for TB has been prepared on the basis of the plan provided in the UP PIP. The plan for TB had a barriers analysis. Also, the high risk districts have already been identified.

## Modified BCC Log Frame 9: Vector Borne Diseases

### Overall Objectives:

- Malaria mortality reduction rate by 50 percent by 2010; Reduction in filarial by 70 percent by 2010; Elimination of kala azar by 2010; Reduction in dengue mortality rate by 50 percent by 2010; Effective control over chikungunya morbidity

Behavioural Objectives				
To increase surveillance of vector borne diseases from ---- to ---- by 2010; To destroy vector breeding sites from ---- to ---- by 2010; To empty water containers once a week				
Barriers	Interventions	Strategy	Activities	Workload
<ul style="list-style-type: none"> <li>▪ Lack of active surveillance</li> <li>▪ Lack of community mobilization and a multi-sectoral response<sup>61</sup></li> </ul>	<p><b>Community Level</b></p> <ul style="list-style-type: none"> <li>▪ Blood smears to be routinely taken at least in 15 high risk malaria districts</li> <li>▪ Child-to-Community BCC and action</li> <li>▪ Village Health &amp; San Committees shld be prepare prevention and control of outbreaks plans</li> </ul> <p><b>State Level: (Mass Media / Print / Local Media)</b></p> <ul style="list-style-type: none"> <li>▪ TV, Radio Spots; Tin Plates; Posters on how to alert authorities on an outbreak</li> <li>▪ Special strategies for outbreaks<sup>62</sup></li> </ul>	<p><b>Strategy 1</b></p> <ul style="list-style-type: none"> <li>▪ Monthly during VHND</li> </ul> <p><b>Strategy 2</b></p> <ul style="list-style-type: none"> <li>▪ Shram daan on Oct 2nd</li> <li>▪ Going House to house one Saturday in a month to empty containers in districts where dengue is high</li> </ul> <p><b>Strategy 3</b></p> <ul style="list-style-type: none"> <li>▪ Telephone number/s and person to be alerted should be stated</li> </ul> <p><b>Strategy 4</b></p> <ul style="list-style-type: none"> <li>▪ Flash BCC campaigns if outbreaks occur</li> </ul>	<ul style="list-style-type: none"> <li>▪ Malaria surveillance to identify fever cases</li> <li>▪ Identify children</li> <li>▪ Outbreak situation: adopt DOT's type approach to empty containers</li> </ul>	<ul style="list-style-type: none"> <li>▪ High priority to endemic/outbreak prone districts</li> <li>▪ Daily airing of TV radio spots in outbreak region</li> </ul>
<ul style="list-style-type: none"> <li>▪ Lack of plans on prevention and control of outbreaks</li> </ul>	<ul style="list-style-type: none"> <li>▪ TV Spots, posters on how to identify mosquito breeding sites and how to destroy it</li> <li>▪ Village Health &amp; Sanitation Committee to monitor spraying and action to destroy mosquito breeding sites</li> </ul>	<ul style="list-style-type: none"> <li>▪ Focus should be on how children can take action</li> </ul>	<ul style="list-style-type: none"> <li>▪ Identify malaria breeding sites</li> </ul>	<ul style="list-style-type: none"> <li>▪ All villages in high risk districts to prepare plans for prevention and management of outbreaks</li> </ul>
				<ul style="list-style-type: none"> <li>▪ No of HHs surveyed/Planned x 100</li> <li>▪ No of vector breeding sites destroyed/Planned x 100</li> <li>▪ No of children participated/Planned x 100</li> <li>▪ No of HHs emptying water containers weekly/Planned x 100</li> </ul>
				<ul style="list-style-type: none"> <li>▪ No of Outbreaks Reported by Village Health &amp; San Comm</li> <li>▪ No of villages with Spraying/Planned Villages x 100</li> </ul>

<sup>61</sup> WHO, SEARO and GOI (2006) "Vector Borne Diseases in India. Report of a Brainstorming Session."

<sup>62</sup> Shukla RP, Sharma SN, Bhat SK. (2002) Malaria outbreak in Bhojpur PHC of district Moradabad, Uttar Pradesh, India. Journal of Communicable Diseases; 34 2 118-123



### Modified BCC Log Frame 10: National Programme for Control of Blindness

Overall Objective: To reduce the blindness prevalence rate by 1 percent to 0.9 percent by 2009 and 0.5 percent by 2012

Behavioural Objectives To conduct 7.52 lakh cataract surgeries in 2008-2009 To conduct eye screening for 50 lakh children 8-14 years					
Barriers	Interventions	Strategy	Activities	Workload	Monitoring Indicators
<ul style="list-style-type: none"> <li>NGO proposals pending</li> <li>IEC has been "sluggish"42</li> </ul>	<p><b>State Level: (Mass Media /Print / Local Media)</b></p> <ul style="list-style-type: none"> <li>During blindness prevention week, run a planned campaign:</li> <li>TV Spots for promoting eye screening &amp; cataract surgery; use CDs also; slides in cinema halls;</li> </ul> <p><b>School Level</b></p> <ul style="list-style-type: none"> <li>School eye screening to be done during 4 school health weeks; planned systematic screening can take place</li> </ul> <p><b>District Level</b></p> <ul style="list-style-type: none"> <li>Plan state and district level functions on June 10th to provide visibility to Blindness Prevention</li> </ul> <p><b>Health Provider/Policy Level</b></p> <p>Selection and up gradation of NGOs</p>	<p><b>Strategy 1</b></p> <ul style="list-style-type: none"> <li>Prepare TV and radio spots with details of eye screening facilities and cataract surgery facilities</li> </ul> <p><b>Strategy 2</b></p> <ul style="list-style-type: none"> <li>Provide simple visual pamphlets on cataract surgery during school screening which children can give to their families and neighbours</li> </ul>	<ul style="list-style-type: none"> <li>Select agency</li> <li>Produce spots</li> <li>Prepare pamphlets</li> <li>Pre-test them</li> <li>Plan school screening programme</li> <li>Plan to show children a film on blindness prevention during the eye screening programme</li> </ul>	<ul style="list-style-type: none"> <li>Development of 1-2 TV and radio spots (or procure from national level)</li> <li>Development of a pamphlet</li> <li>Procure film from GOI</li> </ul>	<ul style="list-style-type: none"> <li>No of cataract surgeries performed/planned x 100</li> <li>No of pamphlets distributed/expected x 100</li> <li>No of children screened/expected x 100</li> <li>No of children received glasses/Expected x 100</li> </ul>

## Annexure 7

### One Year Strategy: Proposed Group Meetings to be conducted by ASHA

	Month	Campaign	Topic for Group Meeting	Key Behaviours	Strategy/ materials
1.	August	Maternal & Newborn Health	Ante-natal Care	Early registration < 12 wks 3 ANC check ups	Story; flashcard/s ( <i>refer ANC cards in ASHA flipbook</i> ); details of when, where ANC check up is available in village
2.	September	Maternal & Newborn Health	Anaemia	Eat 4 times a day Eat an iron rich and Vitamin C rich food daily Take 100 IFA tablets during pregnancy or as suggested by provider	Cookbook; Sharing of daily diet of 2-3 women; Role model of a woman who eats 4 times a day; listing of locally available iron and vitamin C rich foods ( <i>refer nutrition card in ASHA flipbook</i> )
3.	October	Maternal & Newborn Health	Danger signs in pregnancy & Birth Preparedness	Referral for danger signs Transport & emergency arrangements; hosp delivery	Flashcard on danger signs; <i>refer card on danger signs in ASHA flipbook</i> Flashcard on birth preparedness
4.	Nov	Maternal & Newborn Health	Post natal care & Essential Newborn care	Colostrum Breastfeeding within ½ hour of birth Referral for danger signs in newborn Referral for danger signs in mother	Flashcards
5.	December	Bal Poshan Mah/ Water and Sanitation	Water and Sanitation	Use dipper Wash hands with soap after defecation Wash hands with soap	Children to demonstrate use of dipper and Hand washing with soap.
6.	January	Family Planning	Spacing between 2 children	Use IUD Use Oral Pill Use Condom	Satisfied users of spacing methods to share their experience
7.	February	Family Planning	The girl child	Adopt terminal method after 2-3 children irrespective of sex of children	Role model

8.	March	Family Planning	NSV	Adopt NSV	Satisfied client; details of monetary incentives
9.	April	Family Planning	Tubectomy	Undergo tubectomy after 2-3 births	
10.	May	Immun	RI	5 contacts per year per infant	Details of RI sessions, where, when and time
11.	June	Bal Poshan Mah/Water and Sanitation	Water and Sanitation	Use dipper Wash hands with soap after defecation Wash hands with soap	Testimonies of women who have changed their behaviours;
12.	July	Immun	Pulse Polio	Take polio drops per round per eligible child	
13.		One-week TB Campaign			
14.		One-week Blindness Control Campaign			

## Annexure 8

### One Year Strategy: Proposed Group Meetings to be Conducted by ANM

	Month	Campaign	Topic for Group Meeting	Key Behaviours	Strategy
1.	August	Maternal & Newborn Health	Ante-natal Care	Early registration < 12 wks 3 ANC check ups	Story; flashcard/s; details of when, where ANC check up is available in village
2.	September	Maternal & Newborn Health	Anaemia	Eat 4 times a day Eat an iron rich and Vitamin C rich food daily Take 100 IFA tablets during pregnancy or as suggested by provider	Cookbook; Sharing of daily diet of 2-3 women; Role model of a woman who eats 4 times a day; listing of locally available iron and vitamin C rich foods
3.	October	Maternal & Newborn Health	Danger signs in preg & Birth Prep	Referral for danger signs Transport & emergency arrangements; hosp delivery	Flashcard on danger signs; Flashcard on birth preparedness
4.	Nov	Maternal & Newborn Health	Post natal care & Essential Newborn care	Colostrum Breastfeeding within ½ hour of birth Referral for danger signs in newborn Referral for danger signs in mother	Flashcards
5.	December	Bal Poshan Mah/ Water and Sanitation	Water and Sanitation	Use dipper Wash hands with soap after defecation Wash hands with soap	Children to demonstrate use of dipper and Hand washing with soap.
6.	January	Family Planning	Spacing between 2 children	Use IUD Use Oral Pill Use Condom	Satisfied users of spacing methods to share their experience
7.	February	Family Planning	The girl child	Adopt terminal method after 2-3 children irrespective of sex of children	Role model
8.	March	Family Planning	NSV	Adopt NSV	Satisfied client; details of monetary incentives
9.	April	Family Planning	Tubectomy	Undergo tubectomy after 2-3 births	

---

10.	May	Immun	RI	5 contacts per year per infant	Details of RI sessions, where, when and time
11.	June	Bal Poshan Mah/Water and Sanitation	Water and Sanitation	Use dipper Wash hands with soap after defecation Wash hands with soap	Testimonies of women who have changed their behaviours;
12.	July	Immun	Pulse Polio	Take polio drops per round per eligible child	
13.		One-week TB Campaign			
14.		One-week Vector Control Campaign			

---

## Annexure 9

### Information Compilation for BCC Planning at the District Level

(Source: IHMP, 1998 “District BCC Planning for Reproductive & Child Health. Report 2: District BCC Plan”)

#### Section 1

#### Information Requirement for Planning At the District Level

##### I. Demographic Information

###### 1. No. of Villages:

- Number of villages which are inaccessible during monsoon
- Number of villages which have problem related to transportation and communication throughout the year

###### 2. Number of households by block / PHC area / village:

- Total population
- Population by PHC, sub-centre and village
- Percentage of SC and ST in block
- Population by literacy and educational status - male / female
- Population by occupation - male / female
- Worker's participation rate - male / female

##### II. Information related to existing Infrastructure

1. No. of PHC / sub-centres
2. No. of schools/Ashram schools/colleges
3. Transport and communication
4. Adult education centres
5. Non-government Organisations (NGOs)
6. Bazaar/Yatra days

##### III. Media Resources

1. Total no. of cinema theatres, video centres, air stations
2. Radio and TV owners - media reach and access, tape recorders
3. Total no. of cable operators

##### IV. Information on Available Human Resources

###### A. Health Department (sanctioned & vacant)

1. Medical Officers
2. Health Assistants (m & f)
3. Multi Purpose Health Workers (ANMs and MPWs)
4. Traditional Birth Attendants
5. ASHAs
6. Private Doctors
7. Health related staff such as ophthalmic Asst./ Lab. tech. / R.H staff

---

**Block level: EO(H)****B. Educational**

1. Total no. of schools - Primary, secondary, higher secondary, colleges
2. Total no. of teachers - Primary, secondary, higher secondary, colleges
3. Total no. of balwadi teachers
4. Total no. of shiksha mitras
5. Total no. of colleges with NSS and NCC
6. Total no. of NSS / NCC students
7. School children
  - Students - 4th to 7th Std. (m and f )
  - Students - 8th to 10th Std. (m and f )

**C. ICDS**

1. Total no. of AWW
2. Total no. of AWW assistants
3. Total no. of supervisors
4. CDPO and ACDPO

**E. Available Community Resources**

Village level resources:

1. Mahila, Tarun, Bhajan, Krida, Youth mandal, etc.
2. Elected Mahila member's
3. Informal leaders

**To get following information from district data**

**V. Rates**

CBR	IMR	Prevalence of malnutrition
MMR	Couple protection rate	Prevalence of low birth weight babies
CMR	Morbidity of specific illnesses	

**VI. Information on Coverage Of RCH Services And Health Utilisation Behaviour Prevalences:****Maternal Care Services**

- ANC services
- Early registration
- Visits by ANM
- TT injection
- Iron folic acid tablets
- Urine examination
- Blood examination
- Detection and protection of high risk cases

---

## **INC**

- Delivery by trained person
- Institutional deliveries
- Usage of safe delivery kits
- High risk cases - INC referrals

## **PNC**

- 1. Birth weight within 72 hrs. ( i.e. three days)
- 2. Low birth weight babies
- 3. Colostrum feeding
- 4. High risk referrals for mothers

## **Immunisation**

- 0- 12 months
- BCG, DPT3, Polio3, Vit. A, Measles
- Fully immunised
- 12-36 months - DPT, Polio, Booster, Vit.A

## **Anaemia and Vit. A deficiency:**

- 1. Percentage of Anaemia in pregnant women
- 2. Percentage of anaemia in lactating mothers

## **Diarrhoea and ARI**

Diarrhoea:- Prevention: 1. Washing hands after defecation

Using soap/ash

2. Washing hand after cleaning child's 0-3 years,

With soap/ash

3. Using dipper for drinking water

4. Percentage of diarrhoea cases.

5. Referral of severe diarrhoeal cases.

## **A R I**

1. Percentage of ARI cases treated with Cotrimoxazole

2. Percentage of ARI cases referred

3. Increase in knowledge of availability services for ARI (monitoring data)

## **Family Planning**

1. No. of couples with more than three children - (percentage)

- how many are permanent method users

2. No. of couples with two children- (percentage)

- how many are permanent method users

3. No. of couples with two children - (percentage)

4. No. of couples with less than two children - (percentage)

- percentages for permanent and temporary user, non-user



---

**FP Service**

1. Less than 19 years ( < 19 yrs.) married
2. Three children - BCC for contraceptive for permanent
3. Three children - BCC for contraceptive for permanent methods

**MTP**

To access, to get prevalence of illegal abortions

**Nutrition and child growth**

1. Children under three years, who are receiving supplementary food
2. Percentage of severely malnourished children female and male (0-3 years)
3. Weaning: Food to child after completion of four month

## Capacity Building for Block BCC Officer

8 days: BCC Modules 2&amp; 3

## Time-table

## Module 2: Day 1

## BCC and Communication Skills

Session	Topic	CONTENT
1.	What is BCC	Focus on : <ul style="list-style-type: none"> <li>• Behaviour Change</li> <li>• Reasons of performing or not performing a behaviour</li> <li>• Need specific BCC</li> <li>• BCC Coverage</li> </ul>
2	Types of behaviour	3 types of behaviour (HH, service and community) Identifying behaviours and reasons for performing and not performing them (exercise)
		Exercise (continued)
	Lunch	
3	Introduction to communication skills	Communications skills: <ol style="list-style-type: none"> <li>1. Non-verbal skills (compassion)</li> <li>2. Listening skills</li> <li>3. Speaking skills</li> </ol>
4	Need Specific BCC and How to Conduct Home Visit	Why Need Specific BCC? What is Need Specific BCC? How to assess BCC need at household level Steps for conducting home visit
4	Introduction to MNH Home Visit Checklist	Introduction to MNH Home Visit Checklist

---

**Module 2: Day 2****BCC and Communication Skills**

Session	Topic	CONTENT
1	How to conduct home visit	In-class exercise
1	How to conduct home visit	In-class exercise
2	How to conduct follow up of home visit	What is follow up? Why follow up?
	Lunch	
3	How to Conduct Home Visit	Field Exercise
4	How to Conduct Home Visit	Field Exercise

**Module 2: Day 3****BCC and Communication Skills**

Session	Topic	CONTENT
1	Participatory Strategies for BCC	Interactive methods Unfinished stories, role plays, one minute speeches etc.
1	Message Development for BCC	Guidelines for - Posters - Group meetings - Wall writings etc.
2	How to Conduct a group Meeting	Preparatory steps Conducting a meetings Effective messages for a group meeting setting
	Lunch	
3	Prep for presentation	Preparation for presentation on home visit field exercise
3	Presentations	How to conduct home visit
4	Preparation for Group Meeting	Planning for group meeting field exercise according to guidelines provided

---

**Module 2: Day 4****BCC and Communication Skills**

Session	Topic	CONTENT
1	Introduction to NRHM BCC Strategy	Broad Strategy Campaign Strategy Community based strategy
2	Intro. to BCC planning framework	<ul style="list-style-type: none"><li>• Conceptual understanding of BCC planning:<ul style="list-style-type: none"><li>• Purpose of planning</li><li>• Levels of planning</li></ul></li><li>• Importance of Community Diagnosis in planning<ul style="list-style-type: none"><li>• Planning framework at:<ul style="list-style-type: none"><li>a. district level</li><li>b. PHC/ sub centre/ village level</li></ul></li></ul></li></ul>
2	Planning for BCC at the block level	Information required at block level Identifying low coverage villages/sub centre Identifying high risk villages
	Lunch	
3	Field Exercise	Group meeting
3		Group Meeting
4	Preparation for presentation	Outline for Presentation on Group Meeting

**Module 3: Day 1****BCC Planning**

Session	Topic	CONTENT
1	Estimating BCC workload	BCC Workload: ASHA, ANM
2	Developing a monthly BCC micro plan for ASHA and ANM	Sample micro plan for ASHA and ANM
2	Introduction to rates	CBR, IMR, MMR, NMR etc.
	Lunch	
3	Presentations	Presentations of Group Meetings
4		Presentations

---

**Module 3: Day 2****BCC Planning**

<b>Session</b>	<b>Topic</b>	<b>CONTENT</b>
1	Supportive Supervision for BCC	Functions of BCC supervision Qualities of a good supervisor
1	Supportive Supervision	Exercise on developing supportive supervision checklist
2	BCC Monitoring	Input, output and outcome indicators
	Lunch	
3	Community Organisation	Community resources and strengths
3	Roles of Health & San Committee	Developing a 2 point agenda for the first year of the samiti
4	BCC for Community Entitlement and Monitoring	Techniques of community monitoring

### NRHM BCC Strategy: Gantt Chart

Behaviour Change Communication (BCC) Strategy for NRHM in Uttar Pradesh | 140







Sr No	Annexure 11: Gantt Chart Activities	Year 1 Month											
		1 Aug	2 Sept	3 Oct	4 Nov	5 Dec	6 Jan	7 Feb	8 March	9 April	10 May	11 June	12 July
3	ASHA Group meeting ( 2 meetings on FP, 1 Gender) Provider Campaign related to FP Village Health and Nutrition Day IUD Insertion Day (sub-centre level) RCH Camp (block level – 2 a year) World Population Day Local BCC Activities: VHND Event (show TV spots on CD) Felicitation of Couples who Adopt Terminal Methods after 2 children Value of Girl Child: Speech Competition/Panel Disc Delaying First Conception: Role play/discussion	*	*	*	*	*	*	*	*	*	*	*	*
	<b>Child Health &amp; School Health TV and Radio Spots</b>					****	****	****					
	Monthly Growth Monitoring AWW (U-3 yrs) Khushali Diwas	*	*	*	*	*	*	*	*	*	*	*	*





Annexure 11: Gantt Chart		Year 1 Month											
Sr No	Activities	1 Aug	2 Sept	3 Oct	4 Nov	5 Dec	6 Jan	7 Feb	8 March	9 April	10 May	11 June	12 July
6.	VHND Event: For parents of unmarried adolescents: Delay Age at Marriage;  TV/Radio Spots: Delay Age at marriage  Life Skills Sessions in Selected Schools  <b>RNTCP</b>  Radio TV (TB Week)  Rickshaw Panels, wall paintings, hoardings, banners etc.  Newsletter for DOTS volunteers  Posters for DOTS Centres  Khushali Diwas: DOTS for TB Patients: Local Event at village level in week of Feb 23rd for TB  School Programs (TB Week: Feb 24 <sup>th</sup> )	MNH Campaign				Child Health Leprosy Wk	TB Wk	Family Planning					
		*	*	*	*	*	*	*	*	*	*	*	*



Sr No	Annexure 11: Gantt Chart Activities	Year 1 Month											
		1 Aug	2 Sept	3 Oct	4 Nov	5 Dec	6 Jan	7 Feb	8 March	9 April	10 May	11 June	12 July
8.	<b>Vector Borne Diseases</b> TV Spots Identify & destroy mosquito breeding sites Radio spots: alerting health authorities of outbreak VHSC to alert authorities of outbreak World Environment Day: shram daan by children	MNH Campaign			Child Health Leprosy Wk	TB Wk			Family Planning			Adol Health	Hygiene San
9.	<b>Leprosy Eradication</b> Anti Leprosy Week (Jan 30-Feb 5 <sup>th</sup> ) National & District Events Stigma Reduction Campaign	*	*	****		*		****	*	*	*	****	*

## Bibliography

### Vector Borne Diseases

1. Singh N and Shukla MM. Socio-cultural Barriers to Accepting Malaria Chemoprophylaxis by Pregnant Women in Central India. *Journal of Health population Nutrition* 2002 Mar; 20(1): 93-95.
2. Vector-Borne Diseases in India, Report of a Brainstorming Session 2006 Nov.  
[http://searo.who.int/LinkFiles/CDS\\_vector-borne\\_diseases\\_in\\_India.pdf](http://searo.who.int/LinkFiles/CDS_vector-borne_diseases_in_India.pdf); accessed Aug 11, 2008
3. Sharma SN, Shukla RP, Raghavendra K. Impact of DDT spraying on malaria transmission in Bareilly District, Uttar Pradesh, India. *Journal of Vector Borne Diseases* 2005 Jun; 42(2): 54-60.
4. Dhiman RC, Pillai CR, Subbarao SK. Investigation of malaria outbreak in Bahraich district, Uttar Pradesh *Indian Journal of Medical Res.* 2001 May; 113:186-91.
5. Shiv Lal, G.S. Sonal, P.K. Phukan. Status of Malaria in India. *Journal of Indian Academy of Clinical Medicine* 5(1): 20-23.
6. Shukla RP, Sharma SN, Bhat SK. Malaria outbreak in Bhojpur PHC of district Moradabad, Uttar Pradesh, India. *Journal of Communicable Diseases* 2002 Jun; 34(2): 118-23.

### Urban Health

7. Siddharth Agarwal, Arti Bhanot, Kirti Sangar. Neonatal Care and Transport Among the Urban Poor: Challenges and Options. *Journal of Neonatology* 2005 Dec; 19(4): 347-351
8. G. N. V. Ramana, Elizabeth Lule. Reaching Primary Health Services for the Urban Poor: Lessons from India Urban Slums Project.
9. Pandey S, et al.: Delivery practices in an urban slum of Nainital; 210-211.

### Tuberculosis

10. Silvio Waisbord. Behavioral barriers in tuberculosis control: A literature review. The CHANGE Project/Academy for Educational Development 1-14.
11. James N Newell, et al.: Family-member DOTS and community DOTS for tuberculosis control in Nepal: cluster-randomized controlled trial. *Lancet* 2006; 367: 903-09.
12. Improving TB Drug Management – Accelerating DOTS expansion. World Health Organization, Management Sciences for Health, Stop TB Partnership.  
[www.stoptb.org/wg/advocacy\\_communication/assets/documents/BehavioralBarriersTBControl.pdf](http://www.stoptb.org/wg/advocacy_communication/assets/documents/BehavioralBarriersTBControl.pdf)
13. Needham D. Patient care seeking barriers and tuberculosis programme reform: a qualitative study. *Health Policy*; 67(1): 93-106.
14. Thomas R. F. A Persistent Enemy. *Indian Journal of Tuberculosis* 2004; 51:121-122.
15. A Mushtaque R Chowdhury, Chowdhury S, et al.: Control of tuberculosis by community health workers in Bangladesh. *Lancet* 1997; 350: 169-72.
16. V. K. Chadha, P. S. Jagannatha, P. S. Vaidyanathan, S. Singh, Lakshminarayana. Annual risk of tuberculous infection in rural areas of Uttar Pradesh, India. *International Journal of Tuberculosis and Lung Disease* 2003, 7(6): 528-535.

---

17. Dandona R, Dandona L, Mishra A, Dhingra S, Venkatagopalakrishna K, Chauhan LS. Utilization of and barriers to public sector tuberculosis services in India. *National Medical Journal of India* 2004 Nov-Dec; 17(6): 292-9.

#### **Socio-Cultural Factors related to Health**

18. Susan Seymour. Birth on the Threshold: Childbirth and Modernity in South India *Anthropological Quarterly*; Fall 2004; 77, 4; 867-870.

19. Sharma D. Infancy and Childhood in India: A Critical Review. *International Journal of Group Tensions*, Vol. 29 (3/4), 2000; 219-251.

20. Nadja Reissland, Richard BuRGHART. The Quality Of a Mother's Milk and The Health of Her Child: Beliefs and Practices of the Women of Mithila. *Social Science Medicine* 1988, Vol. 27 (5); 461-469.

21. Alok Bhargava. Family planning, gender differences and infant mortality: evidence from Uttar Pradesh, India. *Journal of Econometrics* 2003, vol. 112 (1), 225-240.

22. Kamla Gupta, P. Princy Yesudian. Evidence of women's empowerment in India: a study of socio-spatial disparities. *GeoJournal* (2006) 65: 365-380.

23. David M. Frohlich, Girish Prabhu. Fueling the ethnographic imagination by design. *Hardcopy Technology Laboratory* 2004 Apr.

24. Khanna SK. Gender discrimination, maternal health, and pregnancy outcomes in north India. *UMI Dissertation Services* 1995. [3], 303.

25. Saha, S., T.K.S. Ravindran (2002) Gender Gaps in Research on Health Services in India. *Journal of Health Management*, 4(2), 185-214.

26. Spiro, Alison M. 'Najar or Bhut—Evil eye or ghost affliction: Gujarati views about illness causation', *Anthropology & Medicine* 2005, 12:1, 61 -73.

27. Vani Sethi, Sushma Kashyap, Siddharth Agarwal. Contextual Factors Influencing Newborn Care Amongst Rural Poor in Western Uttar Pradesh. *Pakistan Journal of Nutrition* 2005, 4 (4): 273-275.

28. Perundevi Srinivasan. Stories About Posts: Vedic Variations Around the Hindu Goddess. *Anthropological Quarterly*; Summer 2005; 78, 3; Academic Research Library. 783.

29. Shally Awasthi; Tuhina Verma; Monica Agarwal. Danger signs of neonatal illnesses: perceptions of caregivers and health workers in northern India. *Bull World Health Organization* 2006 Oct, vol. 84 no. 10.

30. Alicia Ory DeNicola. River of Love in an Age of Pollution: The Yamuna River of Northern India, *Anthropological Quarterly*; Summer 2007; 80, 3; Academic Research Library pg. 911.

#### **Family Planning & Reproductive Health**

31. Manju Rani and Sekhar Bonu. Rural Indian Women's Care-seeking Behaviour and Choice of Provider for Gynaecological Symptoms. *Studies In Family Planning* 2003; 34[3]: 173-185

32. Population Projection for India & States 1996-2016 - Registrar General India.



- 
33. Uttar Pradesh data highlights: the scheduled castes, Census of India 2001.
  34. Rob Stephenson, Amy Ong Tsui. Contextual Influences on Reproductive Health Service use in Uttar Pradesh, India. *Studies in Family Planning* 2002, 33(4): 309-320.
  35. Rob Stephenson; Amy Ong Tsui. Contextual influences on reproductive wellness in Northern India. *American Journal of Public Health*; Nov 2003; 93, 11; ABI/INFORM Global pg. 1820.
  36. Rob Stephenson, Angela Baschieri, et al. Contextual Influences on Modern Contraceptive Use in Sub-Saharan Africa. *American Journal of Public Health* July 2007, Vol 97 (7): 1233-1240.
  37. G.R. Varma and A. Rohini. Perceptions of Community on Post-Contraceptive Care by Primary Health Care System in Tribal and Rural Areas of Visakhapatnam District of Andhra Pradesh. *Ethno-Med* 2008, 2(1): 29-32.
  38. Micheal A. Koenig, Gillian H.C. Foo, Ketan Joshi. Quality of Care within the Indian Family Welfare Programme: A Review of Recent Evidence. *Studies In Family Planning* 2000; 31(1); 1-18.
  39. Working paper by K. G. Santhya (2003). Contraceptive Use Dynamics.
  40. Beth E Scott, David W Lawson<sup>2</sup> and Val Curtis. Hard to handle: understanding mothers' hand washing behaviour in Ghana. *Health Policy and Planning* 2007; 22:216-224.

#### **Behaviour Change Communication**

41. Communication for Better Health, Series J, Number 56, Family Planning Programs. JHU, Population Reports
42. A Kamali, et al.: *Lancet* June 14 2003, Vol 361.
43. Nobuya Inagaki. Communicating the Impact of Communication for Development Recent Trends in Empirical Research. The World Bank June 2007.
44. J.Cockburn, W.A.W Walters. Communication between doctors and patients. *Current Obstetrics & Gynecology* (1999) 9, 34-40.
45. Sood, Suruchi, Sengupta, Manisha. and Chandra, Urvashi. "Impact of an Integrated Public Health Communication Campaign on Awareness, Preparedness and Behaviors Related to Maternal and Neonatal Health" Paper presented at the annual meeting of the International Communication Association, 2008-04-22.
46. Arvind Singhal, et al.: New Research Reveals the Success of Taru, PCI'S Indian Serial Drama. *PCI News*.
47. Andy Haines, et al.: Community health-workers: scaling up programs. *The Lancet* June 23 2007, Vol 369: 2058-2059.
48. Mahila Samakhya Uttar Pradesh National Evaluation 2004 Executive summary.
49. IFPS-II Health Communication Strategy For State Innovations in Family Planning Services Agency (SIFPSA) Uttar Pradesh (UP) 2006-2010. Final Draft April 15, 2008 for USAID Review.

---

## Personal Hygiene and Sanitation

50. Param Iyer, Jennifer Sara. The Hand washing Handbook A guide for developing a hygiene promotion program to increase hand washing with soap. The World Bank.

51. Stephen Luby, et al.: Effect of hand washing on child health. The Lancet Sep 10 2005, Vol 366.

52. Stephen P Luby, Mubina Agboatwalla, Daniel R Feikin, John Painter, Ward Billhimer MS, Arshad Altaf, Robert M Hoekstra. Effect of hand washing on child health: a randomized controlled trial. The Lancet July 16 2005, Vol 366: 225-233.

53. Stephen P. Luby, Mubins Aqboatwalla, et al.: Effect of Intensive Hand washing Promotion on Childhood Diarrhea in High-Risk Communities in Pakistan. Journal of American Medical Association 2004, Vol 291 (21).

54. Lorna Fewtrell, Rachel B Kaufmann, David Kay, Wayne Enanoria, Laurence Haller, and John M Colford Jr. Water, sanitation, and hygiene interventions to reduce diarrhea in less developed countries: a systematic review and meta-analysis. Lancet Infectious Disease 2005; 5: 42-52.

## Child Health

55. Zulfiqar A Bhutta, Tahmeed Ahmed, Robert E Black, et al.: Maternal and Child Under nutrition 3 What works? Interventions for maternal and child under nutrition and survival. Lancet 2008; 371: 417-40.

56. UNICEF, Vikram Singh Niranjana. Most Significant Change (MSC) Technique to Assess the Impact of Bal Bandhu Project on Four Key Behaviors in Lalitpur.

## Maternal Mortality

57. Surg VAdm Punita Arora, SM, VSM. Maternal Mortality - Indian Scenario. MJAFI 2005; 61: 214-215.

58. Behavioral Dimensions of Maternal Health & Survival. Mother care Matters. A Quarterly Newsletter and Literature Review on Maternal and Neonatal Health and Nutrition. Volume 9, No. 3—September 2000.

59. Dileep V. Mavalankar, MD, Dr PH, and Allan Rosenfield, MD. Maternal Mortality in Resource-Poor Settings: Policy Barriers to Care. American Journal of Public Health. 2005; 95:200-203.

60. Aggarwal A, Pandey A, Bhattacharya BN. Risk factors for maternal mortality in Delhi slums: A community-based case-control study. Indian J Med Science 2007; 61:517-26.

61. Saumya Ramarao, Leila Caled, Khan M E, Townsend J W. Safer maternal health in rural Uttar Pradesh: do primary health services contribute? Health Policy and Planning; 16(3): 256-263. Journal of Advanced Nursing, Vol 61(3); 244-260.

## National Rural Health Mission/MDGs

62. Kate J Kerber, Joseph E de Graft-Johnson, Zulfiqar A Bhutta, Pius Okong, Ann Starrs, Joy E Lawn. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Lancet 2007; 370: 1358-69.

63. National Family Health Survey (NFHS 3). Fact Sheet India. Ministry of Health and Family Welfare. Government of India. 2005-2006.

- 
64. Countdown Coverage Writing Group, on behalf of the Countdown to 2015 Core Group. Countdown to 2015 for maternal, newborn, and child survival: the 2008 report on tracking coverage of interventions. Lancet 2008; 371: 1247-58.
65. Countdown 2008 Equity Analysis Group\* Mind the gap: equity and trends in coverage of maternal, newborn, and child health services in 54 Countdown countries Lancet 2008; 371: 1259-67.
66. Countdown Working Group on Health Policy and Health Systems, Assessment of the health system and policy environment as a critical complement to tracking intervention coverage for maternal, newborn, and child health Lancet 2008; 371: 1284-93.
67. Dr Siddharth Agarwal, Dr. S. Kaushik and Anuj Srivasatav. State of Urban Health in Uttar Pradesh. Ministry of Health and Family Welfare.
68. National Family Health Survey (NFHS 3). Fact Sheet Uttar Pradesh. Ministry of Health and Family Welfare. Government of India. 2005-2006.
69. Zulfiqar A Bhutta, Indu Gupta, Harendra de'Silva, Dharma Manandhar, Shally Awasthi, S M Moazzem Hossain, M A Salam. Maternal and child health: is South Asia ready for change? Biomedical Journal 2004; 328:816-9.
70. Adam Wagstaff, Flavia Bustreo, et al.: Child Health: Reaching the Poor. American Journal of Public Health May 2004, Vol 94 (5): 726-736.
71. Vani Sethi, Sushma Kashyap, Siddharth Aggrawal, Ravindra Mohan Pandey, Dimple Kondal. Positive Deviance determinants in Young Infants in rural Uttar Pradesh. Indian Journal of Pediatrics June 2007, vol 74: 594-595.
72. Andy Haines, David Sanders, Uta Lehmann, Alexander K Rowe, Joy E Lawn, Steve Jan, Damian G Walker, Zulfiqar Bhutta. Achieving child survival goals: potential contribution of community health workers. Lancet 2007; 369: 2121-31.
73. Neena Shah More, Ujwala Bapat, Sushmita Das, Sarita Patil, Maya Porel, Leena Vaidya, Bhaveshree Koriya, Sarah Barnett, Anthony Costello, Armida Fernandez and David Osrin. Cluster-randomized controlled trial of community mobilisation in Mumbai slums to improve care during pregnancy, delivery, postpartum and for the newborn. 10 February 2008.
74. Vishwajeet Kumar, Saroj Mohanty, et al.: Impact of Community based behaviour change management on neonatal mortality: a cluster randomized, controlled trial in Shivgarh, Uttar Pradesh, India. submitted.
75. Vishwajeet Kumar, Jessica C. Shearer, Aarti Kumar, Gary L. Darmstadt. Neonatal Hypothermia in low source settings: a review. Abstract, 269; Body, 5302.
76. Baqui A.H, Williams E.K, et al.: Newborn care in rural Uttar Pradesh. Indian Journal of Pediatrics 2007; 74(3): 241-247.
78. Rajib Dasgupta, Sanjay Chaturvedi, Vivek Adhish, Kalyan K Ganguly, Sanjay Rai, Leena Sushant and N K Arora. Social Determinants and Polio 'Endgame': A Qualitative Study in High Risk Districts of India. Indian Journal of Pediatrics May 17, 2008 vol 45: 357-365.
79. Universal Immunization Programme Review. Uttar Pradesh.

- 
80. Public Health and Human Rights November 4-8, 2006. South Asia Public Health Association 2006 Annual Meeting.
81. Expert Consultation on Community-Based Approaches for Neonatal Sepsis Management September 26-28, 2007 London, UK. Save the Children/Saving Newborn Lives. United States Agency for International Development.
82. Joanna Morrison, Suresh Tamang, Natasha Mesko, David Osrin, Bhim Shrestha, Madan Manandhar, Dharma Manandhar, Hilary Standing and Anthony Costello. Women's health groups to improve perinatal care in rural Nepal. BMC Pregnancy and Childbirth 2005, 5:6.
83. Pavitra Mohan, Sharad D Iyengar, Sanjana Brahmawar, Kalpana Sen. Auxiliary Nurse Midwife: What determines her place of residence? The Journal of Health and Population in Developing Countries 23 June 2003.
84. Dr. Mandakini Parihar, Improving Access to Quality Care in Family Planning Medical Eligibility Criteria for Contraceptive Use. Consensus on Sterilization guidelines Outcome of the meeting held on March 28th 2004 at Pune and the changes recommended in the FOGSI managing committee held in Jammu on April 16-17<sup>th</sup> 2004.
85. Nupur Barua. How to develop a pro-poor private health sector in urban India? Presentation made at Forum 9, Mumbai, India, 12-16 September 2005.
86. Population policy of Uttar Pradesh. July 2000 Department of Health and Family Welfare Government of Uttar Pradesh.
87. Indian Public Health Standards (IPHS) For Primary Health Centers. GUIDELINES (March 2006) Directorate General of Health Services Ministry of Health & Family Welfare Government of India.
88. Note on Health Sector in Uttar Pradesh December, 2005 Department of Planning, Government of Uttar Pradesh.
89. National Rural Health Mission State Action Plan Uttar Pradesh (2008 - 2009) Department of Family Welfare Uttar Pradesh.
90. Evaluation Study on Functioning of Primary Health Centers (PHCs) Assisted under Social Safety Net Programme (SSNP) Programme Evaluation Organization Planning Commission Government of India New Delhi August, 2001.
91. Status of RCH services in Uttar Pradesh. Uttar Pradesh Voluntary Health Association.
92. Innovations in Family Planning Services Project- An Appraisal. ORG Center for Social Research.
93. SIFPSA (2003-2004). Behaviour Change Communication (BCC) Strategy. State Innovation in Family Planning Services Project Agency.
94. Nazmul Chaudhury, Jeffrey Hammer, Michael Kremer, Karthik Muralidharan and F. Halsey Rogers. Missing in Action: Teacher and Health Worker Absence in Developing Countries. Journal of Economic Perspectives 2006, Vol20 (1): 91-116.
95. Brazil Ministry of Health. "Evolution of Number of Community Health Agents 1994-2001". Brazil Ministry of Health. Brasilia.