National Rural Health Mission (NRHM)

From Awareness to Action

A Guide for District and Block-level Functionaries to Implement Behavior Change Communication Programmes

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Foreword

Behavior Change Communication (BCC) is a core strategy of the National Rural Health Mission (NRHM) for achieving its health goals in Uttar Pradesh. Improving BCC in the development and delivery of health programmes in the state is a goal of the NRHM to improve health programme effectiveness. With this in mind, a comprehensive BCC strategy and implementation plan for all the NRHM activities was developed as a part of the approved implementation program of the NRHM in Uttar Pradesh for 2008-2009. This work was supported by the United States Agency for International Development (USAID) through SIFPSA and IFPS II Technical Assistance Project (ITAP).

Health programme activities developed and delivered at the state level benefit from guidelines outlined in the state's BCC strategy. However awareness and capacity within communities for including effective BCC in health programmes was lacking. This gap highlighted the need to build capacity, and provide guidelines for BCC design and implementation at the district and block level. This guide, ***From Awareness to Action:*** *A Guide for District and Block-level Functionaries to Implement Behavior Change Communication Programmes,* was developed for district and block level programme managers to orient them to the NRHM BCC strategy in Uttar Pradesh, and help them understand the important role of coordinated and cohesive BCC in quality health programmes. It guides district and block level programme managers on integrating BCC from the state strategy into their annual Programme Implementation Plans (PIPs) for impact at the community level.

Written from a layman's perspective, this document provides useful guidelines for designing and delivering BCC activities that are coordinated with the state's BCC strategy to improve effectiveness of the NRHM's health programmes in communities.

Acknowledgements

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Glossary

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
Badhai	Congratulations
Bal Chetak	Child volunteer
BCC	Behavior Change Communication
BSPM	Bal Swasth Poshan Mah
CBO	Community Based Organization
CPR	Contraceptive Prevalence Rate
DCM	District Community Mobilizer
DHEIO	District Health Education and Information Officer
DLHS	District Level Health Surveys
DOTS	Directly Observed Treatment
FGD	Focus Group Discussion
FP	Family Planning
HEO	Block Level Health Education Officer
HH	Household
IDI	In Depth Interview
IEC	Information Education Communication
IFA	Iron and Folic Acid Supplements
IMR	Infant mortality rate
IPC	Interpersonal Communication
IUD	Intrauterine device
JSY	Janani Suraksha Yojna (Safe Motherhood Scheme)
MCH	Maternal and Child Health
MPW	Male Multipurpose Worker
NBC	Newborn Care

NFHS	National Family Health Survey
NGO	Non Governmental Organization
NNM	Neonatal Mortality Rate
NRHM	National Rural Health Mission
NSV	Non Scalpel Vasectomy
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Solution
PCPNDT	Preconception and prenatal diagnostic techniques
PHC	Primary Health Centre
PNC	Post Natal Care
RCH	Reproductive and Child Health
RI	Routine Immunization
RH	Reproductive Health
RKS	Rogi Kalyan Samiti
RTI	Reproductive Tract Infection
SMART	Specific, Measurable, Action-Oriented, Realistic, and Timely
SSKY	Saloni Swasth Kishori Yojna
TB	Tuberculosis
TFR	Total Fertility Rate
UP	Uttar Pradesh
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee

Figures and Tables

Chapter 1

Behavior Change Communication

Understanding BCC and IEC

It is important that District and Block Level Functionaries of health programmes have a conceptual clarity of Behavior Change Communication (BCC), as most programme managers focus only on knowledge creation and awareness through information, education and communication (IEC) and not behavior change. In order to achieve sustainable behavior change, it is necessary to shift from awareness creation to a focus on changing behaviors. The messages below are very simple but highlight the difference between IEC and BCC.

IEC message on a pamphlet at PHC

[Iron is an important nutrient for growth. Increasing your iron intake can improve your health.]

BCC message from an ASHA to a woman during a home visit

[Eating foods rich in iron as a snack between meals, such as a fistful of the nuts from your cupboard, will make you feel better. You'll have more energy each day and be healthier.]

What is Health Behavior?

A behavior is an action. For example, in Uttar Pradesh, 28% rural women receive 3 ANC check ups during pregnancy. The behavior that requires promotion is receiving 3 ANC check ups. It is not enough to simply tell every pregnant woman "go for 3 ANC check-ups". District and block level workers must follow up to see if the behavioral action occurred after the BCC inputs. One cannot assume that women will go for 3 ANC check ups because she was told to have 3 ANC check ups. The main work in BCC is to make sure that the behavioral action occurs.

A behavior is a specific action. Other health behaviors include *washing hands with soap after defecation, eating iron rich food daily, using modern family planning methods,* and *taking iron tablets during pregnancy*. So, behaviors include small and big actions that can be carried out at the individual, household and community levels. Many times it is difficult to carry out these actions. For example, if there is no transportation available in the village late at night, how can a pregnant woman have a hospital delivery? Therefore it is important to identify the barriers to behavior change.

What is Behavior Change Communication?

It is important to build a common understanding of the term "Behavior Change Communication." Behavior Change Communication is a process that strategically uses a mix of communication media in order to motivate a targeted audience to adopt specific behaviors. BCC includes *all* the efforts undertaken to motivate people to adopt healthy behaviors. It includes use of TV and radio spots; posters and flip books; and most importantly interpersonal communication (IPC) and the community-based efforts of the ASHA, ANM, AWW and medical officers.

What is Behavior Change Communication?

BCC is about changing specific behaviors – "well defined actions at the household, community and health service levels".

BCC approaches recognize that behavior change is more about identifying the causes and barriers to behavior change and overcoming the barriers. It is about understanding the communities, contexts and environments in which behaviors 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

In-press, "Non-Cognitive Determinants of Behavior Change"

Assessing Barriers to Behavior Change

In order to achieve sustainable behavior change, it is essential to understand the barriers to adopting a certain behavior. Once the barriers to adopting the behavior have been identified, the communication activities should seek to address those barriers. Some barriers may be common to the entire village such as irregular visits by the ANM to the village but some barriers may be specific to households.

Example:

Objective: Reduce maternal mortality in UP from 517 per lakh live births to less than 360 per lakh live births by 2010.

Behaviors contributing to objective:

1. Women and adolescents eat 3 times a day (pregnant women 4 times a day);
2. Delay marriage until after 18 yrs, delay first pregnancy until 21 years for girls;
3. Early registration of pregnancy (<12 weeks), 3 ANC checkups;
4. Institutional delivery, and stay in the hospital for 24 hrs after delivery;
5. Immediate health seeking behavior on recognition of danger signs in mother and newborn;
6. Increase birth interval to three years;

7. Adopt any limiting method after two children even if both are girls.

Behavior 1: "Women and adolescents eat 3 times a day; pregnant women eat 3-4 times a day."

How behavior 1 contributes to objective: What a person eats daily, how many times s/he eats and how much s/he eats has enormous implications for one's health and well being. Women and adolescent girls who eat less are undernourished and often suffer from anemia. The consequences of anemia are severe, sometimes lasting for many years or throughout a woman's life. Anemia sometimes results in undesirable outcomes of pregnancy, and severe anaemia can even lead to maternal deaths. In fact, about 20% of maternal deaths are attributed to anemia. Babies born to anaemic mothers are invariably low in birth weight, and their health may be compromised in other ways. Another way in which anaemia affects a woman's life is by reducing her energy levels and capacity to work. Anemia and undernutrition can be prevented, even with limited resources. A nutritious and iron rich diet can be provided to adolescent girls and women. So an important behavior that needs to be promoted in each district is that women and adolescent girls eat at least 3 times a day; and pregnant women eat atleast 4 times a day.

Barriers to adopting behavior 1:

1. Pattern of eating only twice a day
2. Women eat last
3. Food restrictions during pregnancy
4. Belief that baby will not grow if woman eats too much during pregnancy
5. Poverty; issue of food security of the household
6. Women and girls rarely ask for a second helping of food

Once the barriers to adopting a specific behavior are understood, managers can then begin to design interventions and activities to address the barriers. In this case, start to think about how to address the norm of eating twice daily, or how to ensure that women feel comfortable asking for more food.

Introduction to the UP BCC Strategy

Chapter 2

The BCC strategy of the NRHM identifies 27 priority behaviors for change based on health needs in Uttar Pradesh, and proposes a roadmap of interventions to address those needs through state, district and block level program managers and workers through specific roles and implementation plans for each intervention. These priority behaviours can be found in Annexure A.

Key elements of the NRHM's strategy include:

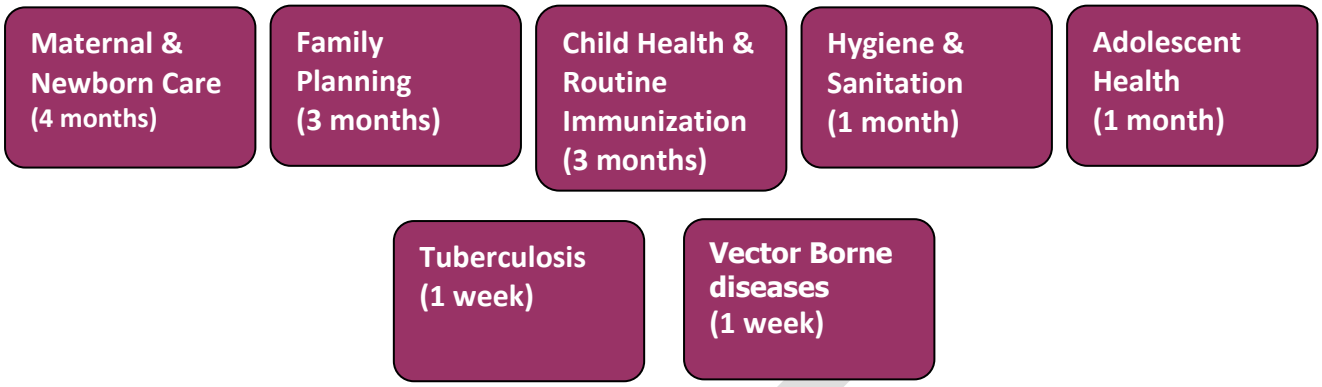
- Priority behaviors and targeted interventions addressing the most critical health needs;
- Activities and interventions delivered through converging channels of communication;
- A coordinated implementation plan for interventions across the state of UP, districts, and blocks; and delivered through health program managers and workers at all levels.

The NRHM BCC strategy recognizes the importance of using a mix of media to reinforce messages and ensure sustainable behavior change. The core of the strategy revolves around (1) interpersonal communication (IPC) and community level BCC activities, with support from (2) mass media and (3) community mobilization interventions. Interventions are proposed at four levels:

The NRHM has selected five core health areas for intended behavior change; and all interventions and activities delivered through IPC and community events, community mobilization, and mass media will be coordinated and focused accordingly (Figure 2.1). By following this schedule yearly, community based activities will be coordinated with state-level mass media efforts, and interpersonal communication through local health workers, thereby reinforcing messages and supporting behavior change across the community and household levels.

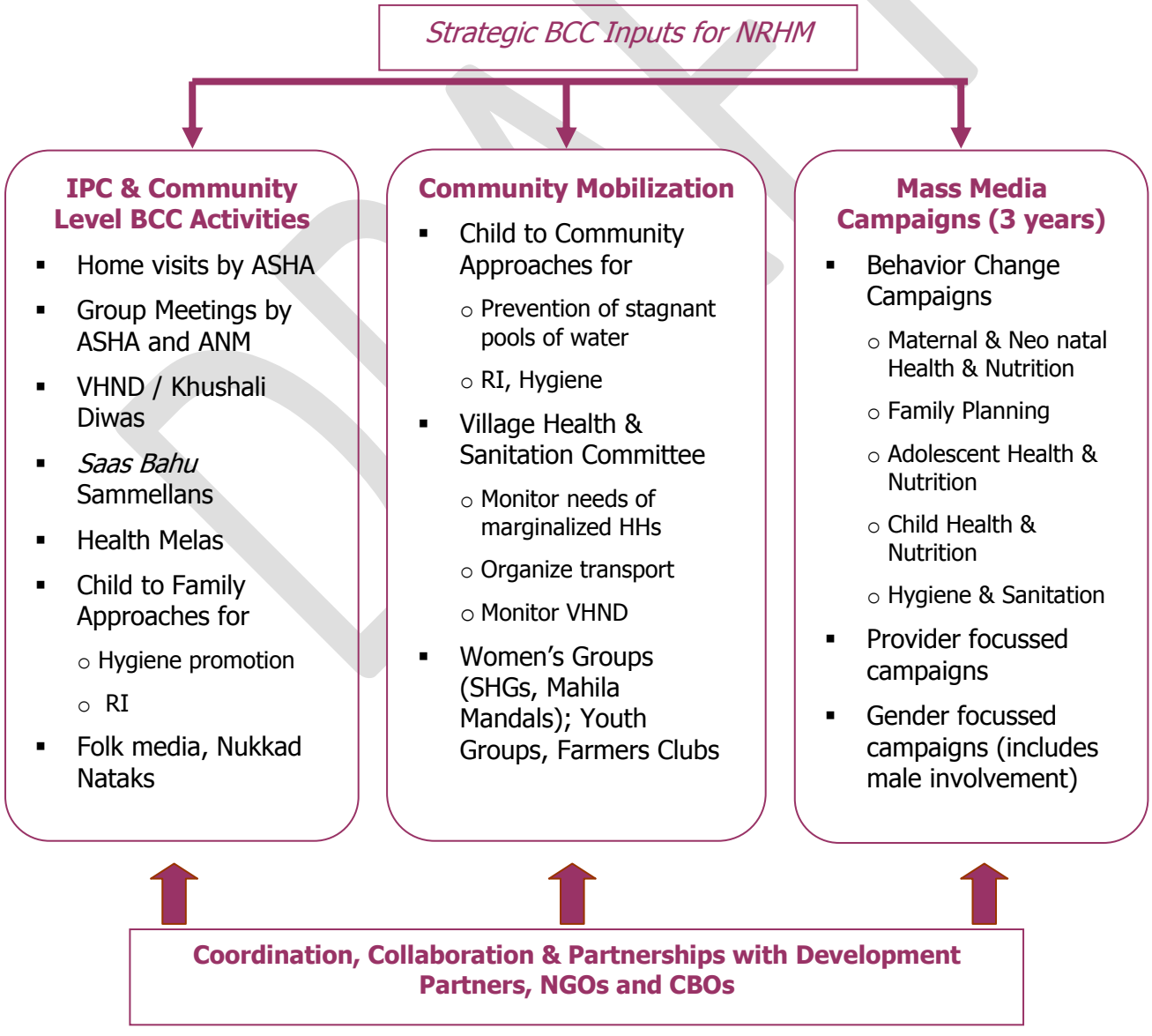
In addition to the five core health areas, the NRHM proposes activities for tuberculosis and vector-borne disease prevention.

Figure 2.1: Campaign Strategy (Every year for 3 years)



To address needs across these five core health areas, a set of interventions at each of three levels – IPC, community mobilizaton and mass media – are proposed. Figure 2.2 displays how these interventions are coordinated across converging communication channels.

Figure 2.2: Strategic BCC Inputs for Campaigns



A roadmap for delivering these interventions will be provided in this report, and will include roles of state, district, and block level program managers and workers, and action plans for implementation.

BCC Innovations

While many BCC interventions prescribed in the state strategy will be described in this report, implementation at the district or local level provides an opportunity for innovation, flexibility, and adaptability. Through innovative activities and intervention deliveries, districts and blocks can most effectively address health needs, and social and cultural influencers in their communities.

Some of the innovative intervetions that might be used or adapted for specific communities include:

- ***IPC tool for home visits***: A simple visual BCC checklist to be used by ASHAs during home visits to assess needs, identify behaviors for change, assess barriers and propose client-centered solutions

- ***Shubh Vivah Kits*** for newly married couples and ***Badhai Kits*** for newborns: Provide key information on contraception, newborn care, diet, and spousal communication

- ***Community notice boards***: For promoting village events and health information such as *Village Health and Nutrition Days*, or routine immunization events

- ***Bal Chetak strategy***: Child volunteers mobilizing families and communities to increase RI coverage and promote hygiene messages

- ***Colour coding for RI campaigns***: A colour coded scheme to simplify timing and planning of routine immunizations for children

- ***Saas Bahu Sammellans***: Generating communication between mothers-in-law and daughters-in-law regarding first conception, family support during pregnancy and importance of institutional delivery

- ***Village report card***: Large growth cards in the Gram Panchayat office

Chapter 3 Situational Analysis

Health of communities and families improves with reductions in infant, child and maternal mortality, and fertility rates; increases in contraception use and age at marriage; and improvements in adolescent health, hygiene and sanitation, immunization, nutrition, and disease prevention. To determine priority health areas for BCC interventions in UP, a situation analysis was conducted and indicators for child and maternal health, and family planning are presented here.

Infant Mortality

IMR
Probability of a child born in a given period of time dying before age one

Uttar Pradesh's infant mortality rates (IMR) are the highest in India – 69 per 1000 live births compared to 57 per 1000 for India. Across UP, districts vary widely. Only 15 districts have IMR less than 70 per 1000 live births and ten districts have an IMR higher than 95 per 1000 (Table 3.1).

Table 3.1: 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
57 per 1000 Live Births	**73 per 1000 Live Births**	Sitapur **(97)**, Bahraich **(99)**, Maharajganj **(99)**, Allahabad **(100)**, Shahjahanpur **(100),** Lalitpur **(99)**, Etah **(104)**, Hardoi **(106)**, Balrampur **(107)**, Badaun **(110)**

Source: S.Irudaya Rajan et al, "Infant and Child Mortality in India: District Level Estimates" New Delhi, Population Foundation of India, 2008

Child Health

The health of UP's children is dire. Only 7% newborns are breastfed within an hour, 23% children (12-23 months) are fully immunized, and a mere 7% received Vitamin A. Almost half of UP's children under three are underweight, and 85% are anemic. Indicators with better coverage are exclusive breastfeeding for six months (51%) and introducing complementary feed at six months (46%). (Figure 3.1)

Figure 3.1: Child Health Indicators in Uttar Pradesh (NFHS-3) (all UP figures)

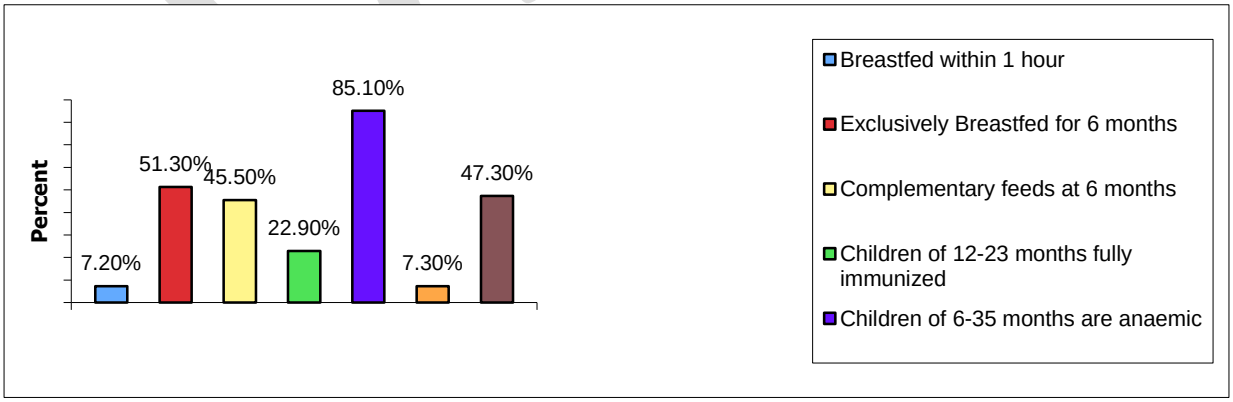


Table 3.2 presents data on child health for the urban poor, rural areas, district averages and the 10 worst performing districts in Uttar Pradesh. Breastfeeding within the first hour is only 5.5% for the urban poor and 6.9% in rural areas. More than half of UP's districts (45) are below the UP average for this already low performing indicator. The practice of giving the newborn prelacteal feeds is very

high, with reports of 87% for both the urban poor and rural populations. ORS coverage is also low as is complete immunization. Conversely treatment seeking for ARI and fever symptoms is high.

Table 3.2: Child Health

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

Maternal Health

Maternal health indicators are very low in Uttar Pradesh. Only half as many women in UP (26%) reported receiving full antenatal services compared with all women in India (52%). Only 8.7% reported completing a full dose of iron and folic acid; institutional deliveries were low at 22%, and only 14% of women received a visit from a health care worker within 48 hours of delivery. Table 3.3 displays maternal health coverage for urban poor and rural areas, and highlights district variations.

Table 3.3: Maternal Health Indicators in Uttar Pradesh

Indicators	India (NFHS 3) 2005-2006 %	UP Urban Poor (NFHS 3) %	UP Rural (NFHS 3) %	UP RCH (DLHS) 2002-2004%	Number Districts below UP Average	10 -12 Worst Performing Districts
3 ANC Visits	50.7	Data not available	22.6	22.3	37	Bareilly, Sitapur, Fatehpur, Etah, Bahraich, Lakhimpur Kheri, Auraiya, Kannauj, Shahjahanpur, Farrukhabad, Hardoi, Badaun
100 IFA Consumption	22.3	22.9	6.7			**Data not available.**
Received No TT Injections	19.2	Data not available	30.2	37.1	31	Etawah, Hathras, Auraiya, Etah, Fatehpur, Kannauj, Shahjahanpur, Jalaun, Farrukhabad, Hardoi, Badaun, Kanpur Dehat
Institutional Delivery	40.7	13.1	17.5	24.5	29	Lakhimpur Kheri, Auraiya, Kaushambi, Kannauj, Bahraich, Farrukhabad, Hardoi, Shravasti, Badaun, Siddarthnagar, Shahjahanpur, Balrampur
Post natal visit by health provider	14.2	Data not available	9.9	33.8	39	Ghazipur, Sitapur, Pilibhit, Jaunpur, Lakhimpur Kheri, Shahjahanpur, Gonda, Sant Kabir Nagar, Balrampur, Shravasti, Siddarthnagar, Bahraich

Age at Marriage, Contraception Use and Fertility

Fertility is another area that requires urgent action. Uttar Pradesh has the second highest total fertility rate (TFR) in India after Bihar (NFHS 3). UP's TFR is 3.8 compared to India's 2.7. UP's contraceptive prevalence rate (CPR) shows an overall low use of modern methods. While the use of temporary contraceptive methods are uniformly low in India and Uttar Pradesh, there is a considerable lag in UP's coverage of female sterilization. UP's indicators of permanent methods (sterilization) declined from 1998 to 2006 (Table 3.4).

TFR
Average number of children born to a woman to the end of her child-bearing years

CPR
Proportion of women of reproductive age who use, or whose partner uses a modern or traditional method

Table 3.4: Family Planning Methods

Indicators	India NFHS 3 2005-2006 %	UP (NFHS 2) 1998-1999 %	UP NFHS 3 2005-2006 %	UP DLHS 3 2006%	Number Districts below UP Average	10 -12 Worst Performing Districts
Condom Use	**5.3**	**4.0**	**8.7**	**7.1**	**47**	Sant Ravidas Nagar, Azamgarh, Jaunpur, Maharajganj, Sonbhadra, Gonda, Pratapgarh, Bahraich, Ballia, Shravasti, Balrampur, Siddarthnagar
IUD Use	**1.8**	**0.9**	**1.4**	**1**	**40**	Barabanki, Gorakhpur, Sultanpur, Azamgarh, Maharajganj, Ballia, Mahoba, Agra, Ambedkar Nagar, Kushinagar, Balrampur, Lalitpur
Oral Pill Use	**3.1**	**1.2**	**1.7**	**1.7**	**42**	Kaushambi, Mau, Pratapgarh, Hamirpur, Barabanki, Ballia, Badaun, Chandauli, Ghazipur, Mahoba, Sant Kabir Nagar, Banda
Female Sterilization	**37.3**	**17.3**	**14.1**	**16.5**	**39**	Mainpuri, Shahjahanpur, Siddarthnagar, Gonda, Etah, Hardoi, Badaun, Kannauj, Farrukhabad, Shravasti, Bahraich, Balrampur
NSV	**1**	**0.5**	**0.2**	**0.2**	**32**	Bahraich, Hamirpur, Agra, Ghazipur, Mau, Hathras, Kanpur Dehat, Lakhimpur Kheri, Barabanki, Firozabad, Farrukhabad, Balrampur

Young married women need special focus due to shorter birth intervals and higher risk of adverse maternal and neonatal health outcomes. About 61% of women 20-24 yrs in UP were married before 18 years. About 30% young married women (15 -19 yrs) have very short birth intervals (7-17 months) compared to 15.1% in women 20-29 years.

Chapter 4

BCC Campaigns & Activities of the 2010-2011 PIP

The UP Programme Implementation Plan (PIP) has included the following activities from the NRHM BCC activities for 2010-2011. The priority areas selected for BCC activities for the year 2010 – 2011 in accordance with the above core behaviors are:

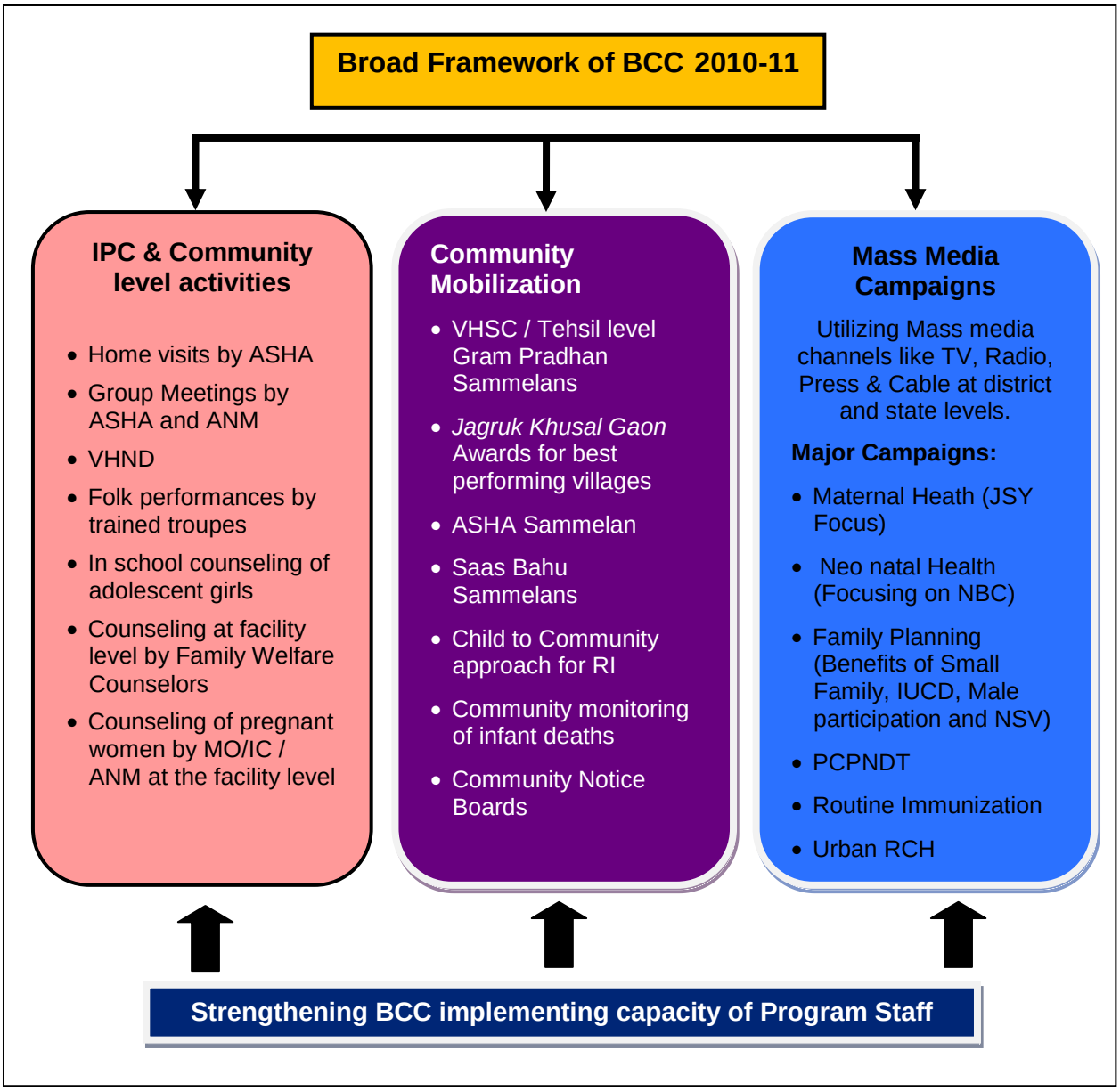
Table 4.1: Priority BCC Activities 2010-2011

BCC Campaigns	Priority Behaviors	Target Audiences	
		Primary	Secondary
Maternal and Newborn Health	Complete ANC: 3 ANC checkups, 100 IFA, 2 injections TT	Married women of childbearing age	Husbands, Older women in households
	Institutional deliveries and stay in hospital for 48 hours (Focus on *Janani SurakshaYojana*)	Pregnant Women and their Husbands	Decision makers in households –Mother in-laws
	Essential New born care (skin to skin care, cord care, immediate & exclusive BF)	All married women of childbearing age	ASHA, AWW, Older women in family
Child Health	Routine Immunization; biannual supplementation of Vitamin A	Men and women of childbearing age	ASHA, AWW, Older women in family
	Exclusive breastfeeding for 6 months	Pregnant and postpartum women	
	School health Program	School children and teachers	Caregivers, General community
Family Planning	Increase birth intervals (with focus on Cu 380 A-IUCD and PPIUCD)	Couples with spacing needs (counseling at pregnancy and continuing till post partum period)	ASHAs, AWW, ANMs, Community influentials, Mothers-in-law
	Increasing men participation in Contraception.	Married Men	VHSC & Community influentials, ASHAs, ANMs, ,
	Use of Limiting methods (with focus on NSV)	Couples achieving desired family size	ASHAs, AWWs, ANMs, Community influentials, Mothers-in-law
	PCPNDT- selective sex determination	Couples in reproductive age; Service Providers; Private clinics	General community, community influentials
Adolescent Health (Saloni Swasth Kishori Yojna)	Health, Hygiene, Nutrition, Age at marriage, negotiation/ life skills.	Adolescent girls Teachers	Parents of adolescent girls, general community, community influentials ANM, AWW ,ASHA

BCC FRAMEWORK FOR PIP 2010-11

Mentioned below is the broad BCC framework for 2010-2011. The detailed workplans for the district and block level functionaries will be designed to ensure that these campaigns and activities are planned, conducted, monotired effectively to have behavioral impact.

Figure 4.1: Broad Framework of BCC 2010-2011



The district and block level functionaries are largely responsible for ensuring that the IPC and community level activities are implemented. While they are not presonsible for the mass media activities they need to ensure that their activities at the village, block and district level are in tandem with the mass media campaigns implemented by the state. The activitiy details for each of the above activities that the ASHAs, ANMs, MPWs are in the Annexures.

A. MATERNAL AND NEWBORN HEALTH BCC CAMPAIGN

Increasing awareness about institutional deliveries: Under the NRHM, one of the key objectives is to reduce by half the maternal mortality rate. The key strategies for reducing maternal and infant mortality are to promote 3 ANC check ups and institutional deliveries in both urban and rural areas.

While there has been an increase in demand for institutional deliveries by the introduction of *Janani Suraksha Yojna* with over 15.40 lac JSY deliveries until December 2009, there is still a need to focus on increasing the demand for JSY to achieve the target of 21.00 lac JSY deliveries being proposed for 2010-2011.

There will be a special multi-media campaign using mass media, interpersonal communication, local and mid media to increase awareness of *Janani Suraksha Yojna* and with emphasis on safe motherhood and need for complete Ante natal care and postnatal care.

Exclusive and immediate breast feeding, and adoption of appropriate new born practices to prevent neonatal mortality: Neonatal mortality is as high as 48/1000 live births in the state. Sixty-seven (67)% of the deaths in children are attributable to neonatal deaths in the first 28 days of life (NFHS-3). Generally, 20% of the neonatal deaths can be prevented if deaths on the first day are reduced. The situation is complicated by harmful socio-cultural practices like not feeding the neonate colostrum, bathing the new born, and applying oil/ ghee/mud to the freshly cut umbilical cord. An exhaustive evidence review was carried out with the help of development partners which highlighted the importance of using inter-personal communication for changing behaviors and integrating BCC efforts across multiple platforms using the continuum of care approach to deliver key messages consistently. Actively involving the community leads to results and community based groups are a good platform to deliver BCC messages.[1]

This calls for urgent action through an integrated intensive approach to educate the community about harmful practices and to promote the correct newborn care practices.

- ***COMMUNITY LEVEL (NBC CONTACT 1):*** *Neo natal care messages to be given to the community during the Saas Bahu Sammelans*

As harmful neonatal practices are deeply rooted in socio-cultural practices, it is necessary not only to educate the woman but also the mother-in-law about the adverse effects / dangers to the infant's life through the existing practices but also to inform them about the correct appropriate neo-natal behaviors. The *Saas Bahu Sammelans* (Annexure B) are already being implemented in the state and have wide social acceptability. A special module with interactive games will be added to the existing activity with focus on saving newborn lives.

- ***FACILITY LEVEL (NBC CONTACT 2):*** *Counselling of pregnant woman & family members during third trimester at the Godbharai ceremony*

A new initiative of "*Godhbharai* ceremony" involving blessing of the pregnant woman in the third trimester is being planned. The ceremony will use the existing cultural practices and the opportunity provided by the ceremony to counsel the pregnant woman and family members at the facility about nutrition and general care, the expected date of delivery (EDD), the 3 delays that could jeopardize the lives of the mother and the unborn child, danger signs and help in the birth planning for each pregnant woman.

[1] Community-based interventions that improve newborn health outcomes: A review of evidence in South Asia.; VISTAAR, Evidence Review Series 5, March 2008

Counselling of the woman and the mother-in-law by the MO/IC and ANM about appropriate neo-natal practices would be initiated during the pregnancy at the *Godbharai* ceremony being proposed at the facility level. A Pregnancy / MNH guide will be handed to the woman focussing on nutrition, care during pregnancy, importance of institutional delivery, Immediate & exclusive breast feeding, prevention and management of hypothermia, appropriate cord care and immunization.

- ***FACILITY LEVEL (NBC CONTACT 3):*** *Stay at the hospital for 48 hours*

In UP since most infant deaths happen within the fist day after delivery, there is a need to ensure the mother and child stay at the hospital for a minimum of 48 hours. It is recommended that the JSY payment be given to the beneficiaries only after 48 hours to promote the stay in hospital for 48 hours after delivery. This would also provide the opportunity for counselling of the parents and the family, especially the women family members. The immediate and exclusive breast feeding behaviors can be supervised by the providers at the facility along with behaviors related to cord care and prevention and management of hypothermia.

Twenty-four/seven (24x7) facilities are being equipped with audio visual sets (TV & DVD players) in maternity wards through funds from RKS. A set of 4-5 minute short films on maternal and child health / care is being proposed which will be available for viewing in the wards.

- ***FACILITY LEVEL (NBC CONTACT 4)****: Counselling of the mother & family members on correct new born practices by Family Welfare Counsellors; giving of "Badhai Kit"*

Counselling at the facility level on exclusive and immediate breast feeding and essential new born care, and follow up by ASHAs to identify danger signs in neonates will be the main thrust of the awareness generation activities. A "*Badhai*" kit consisting of a vest (*baniyain* printed with NBC messages) and IPC material like the MNH guide will be given to the parents of new borns along with counselling by the Family Welfare Counsellors.

- ***HOUSEHOLD LEVEL (NBC CONTACT 5&6)****: Two home visits by ASHAs and AWW for PNC and monitoring of new borns*

There is evidence to show that convergence between the ICDS and the Department of Health produce "better results". The ASHAs and the AWWs will play a crucial role in monitoring the mother and the new born child through the post natal home-visits. The ASHAs and AWWs will be provided training in identification of danger signs in neo-nates so as to counsel the family members and the mother. The first PNC would be delivered by the ASHA & AWW within 7 days followed up by the second PNC visit within 21 days. The ASHA/ AWW would monitor the health of the new born and re-emphasize the exclusive breast feeding and behaviors related to management of hypothermia and cord care (Annexure C).

- ***INTEGRATION WITH PULSE POLIO:*** *Infant monitoring*

Every opportunity for infant monitoring should be utilized to emphasize the importance of adopting appropriate new born behaviors. The Pulse Polio house- to -house teams will be trained to identify danger signs in newborns and to reiterate the priority new born behaviors

- ***COMMUNITY AUDIT & AWARD :*** *Infant death audit; Community Notice boards*

Communities play a vital role in changing socio-cultural practices and acceptance of new practices. Community ownership / involvement may require a focus on more than new born care (broader heath issues)[2]. Infant death audits are being proposed in the programme to sensitize the community to the infant deaths and to provide an opportunity for introspection and debate within the community. This would be coordinated by the ANM with support from the VHSC. The infant death audit guidelines would be detailed in the VHSC advocacy booklet being proposed. Quarterly reporting and monitoring of the village performance on 5 indices is proposed through village level community notice boards at the Panchayat Ghars: (1) Number of Infant Deaths; (2) Number of Maternal Deaths; (3) Number of children < 5 fully immunized/ Total number of >5 children; (4) Number of NSV acceptors; (5) Number of acceptors of female sterilization.

An annual Award & Certificate for the best performing village (*Jagruk Khushal Gaon*)/ Block would be awarded at the Tehsil Level *Gram Pradhan* Sammelans. Rs 1000/- per block is for purchase of awards and printing certificates is being provided in the IEC/BCC budget.

MASS MEDIA & MID MEDIA ACTIVITIES:

An intensive burst of mass media and mid media activity at the state level is planned to build an enabling environment for promoting awareness about appropriate new born practices. Folk performances would be used to convey NBC messages to media dark villages to support the mass media campaign.

- ***MEDIA ADVOCACY EFFORTS:***

Activities are being planned around special days like the Safe Motherhood Day (April 13), Breast feeding week (August 1-8) and the New Born Care Week (Nov 14 -21) to give added impetus to the multimedia campaign on maternal health and JSY. Media advocacy would be used strategically to generate awareness, dialogue and support dissemination of priority behaviors related to maternal and newborn health through mass media channels by ensuring valuable editorial space. These are being planned as new campaigns which will require material development and production for the campaign. Small scale formative research to identify and help in developing key messages can be undertaken.

Table 4.2: Activities Planned under Maternal and Newborn Health Campaigns

Inter personal Communication HHs and community level	**Mid Media / Local media**
Household Level • Home Visits by ASHA for need based counseling (IPC tools & leaflets for community) • 2 PNC visits by ASHA & AWW for infant monitoring and New Born Care **Village Level:** • VHND for ANC / PNC service provision **Community Level:** • Saas Bahu Sammelan • Group Meetings by ASHA / ANM on monthly themes	• Wall paintings with details of JSY, Exclusive BF, New born care, Complete ANC ○ ASHA home ○ Sub centers ○ PHCs ○ District Hospitals • Posters (4 types on JSY, EBF, NBC & ANC & PNC) • Standard treatment & Protocol charts at facility level

[2] Ibid

• Community infant death audit • *Jagruk Kushal Gaon* Awards **Facility Level**: • Counselling of pregnant women by FW Counsellor • Godbharai ceremony: Counselling of pregnant women in third trimester at the facility on EDD, 3 Delays, Danger signs, Nutrition, EBF, PNC & PPFP Counselling of mother & family members on New Born Care practices and *Badhai Kit*	• Folk performances on MNH by trained troupes • Community notice boards for monitoring village level performance on 5 parameters: ○ Infant deaths ○ Maternal deaths ○ Immunization status ○ Acceptance of NSV ○ Acceptance of female sterilization

B. FAMILY PLANNING BCC CAMPAIGN

Of currently married women of reproductive age in UP, about a third (35%) are currently users of any method; over a quarter (27%) are current users of any modern method of which 17% is attributable to sterilization and only 9% to modern spacing methods (condoms, pills, and IUDs). Cultural beliefs such as the desire for male child and the social norm to prove fertility promote the practice of bearing children soon after marriage.

Promoting small family norm: In order to make spacing methods a social norm among couples, a mix of IPC and community based activities at the village level will be undertaken to promote healthy spacing and timing of pregnancies. This will be supported by a mass media campaign promoting the small family norm and basket of contraceptive choices.

Demand generation for IUD: There is a renewed emphasis on promotion of IUDs in the state by increasing numbers of trained providers for IUD. Divisional level clinical training centers are being established at the 18 divisional headquarters of the state. In light of the increased availability of the trained providers, a special campaign focused on promotion of the IUD will be undertaken by modifying the creatives developed by SIFPSA for promotion of IUD 380 A *(*modification of *SUVIDHA campaign).*In addition IUD will also be promoted as a post partum long acting contraceptive method through local activity in districts having trained providers for post partum IUD.

Demand generation for NSV: Non Scalpel Vasectomy (NSV) commonly known as the "no cut, no suture" method (*Bina chira, bina tanka*) is characterized by less pain, fewer complications and quicker return to sexual activity than conventional vasectomy. Misconceptions of vasectomy causing weakness both physically and sexually and requiring long periods of rest following the procedure are common. Many providers including ANMs have little information on the details of the procedure and are reluctant to counsel on it. There is also little awareness about the incentive scheme for NSV both for the acceptor and the motivator. Given the programme emphasis on establishing the training centers for NSV providers, it is proposed to promote NSV in the local media to generate client load for the trained NSV providers. Local media activities featuring names, addresses and contact numbers of trained providers will be implemented. Activities will include local radio channels, local newspapers, street plays, signages, posters, banners and pamphlets.

Preventing female foeticide (PCPNDT):
Declining sex ratio and preference for a male child has adversely impacted the reproductive health of women leading to multiple pregnancies and high maternal mortality and morbidity. Ironically the declining sex ratio is more prevalent in the more prosperous western districts of UP (greater emphasis on districts bordering Haryana & Rajasthan) with higher literacy rates and better health indices.

IEC activities for generating awareness and community participation for building consensus and social sanction against female foeticide amongst the community and service providers have been planned at the state level and at the district level and are explained in detail in the section on PCPNDT. State level sensitization workshops, district specific activities for awareness generation like rallies, competitions at Inter/ Degree colleges, local radio, cable and press, wall paintings, hoardings and signages will be planned.

Table 4.3: Activities Planned under Family Planning Related Campaigns

Inter personal communication HHs and community level	Mid Media / Local media
Household Level • Identification of clients for spacing and limiting through household visit by ASHA • Home visit by ASHA to promote birth planning. **Village Level** • VHND - Counselling of pregnant women by ANM on PPFP during ANC visit **Community Level** • Monthly group meetings for promotion of small family norm by ASHA & ANM as per monthly themes • Saas Bahu Sammelan • Group discussions / meeting through the VHSC for encouraging male participation in FP decision making **Facility Level** • Counselling of pregnant women on PPFP during ANC, delivery and PNC visits by ANM, FWCs, MO/IC	• Wall Paintings on benefits of small family/ right age at marriage/ NSV/ IUCD: ○ ASHA home ○ Sub Centre ○ PHCs / CHCs ○ District hospitals • Folk performances on FP / NSV / IUCD/ PCPNDT / Male participation by trained troupes • Street plays for NSV • Street plays for PCPNDT (district level) • Competitions at Inter/ Degree colleges for PCPNDT • Workshops at Panchayat level for community felicitation of men as positive role models for spacing and/or limiting • Posters for IUCD, NSV, FP (basket of contraceptives) • IPC materials for use by ASHA during home visits and group meetings: ○ FP guide for spacing and limiting ○ NSV Pamphlets & IUCD Handbill

C. CHILD HEALTH AND ROUTINE IMMUNIZATION BCC CAMPAIGN

The areas for communication interventions that have been identified are child nutrition and routine immunization.

Increasing Routine Immunization: There has been stagnation in rates for routine immunization in the state with only 30.3% of children under one year being completely immunized (DLHS-3). Some of the barriers to complete and timely immunization are lack of awareness about services, immunization schedules, prevailing myths and misconceptions, high dropout rate, low parental motivation and lack of community ownership of the immunization programme.

A high visibility and an intensive BCC campaign is being proposed for promotion of parental responsibility for ensuring **complete immunization** of the children. The campaign will use mass media channels like radio, television, and print for dissemination of the messages. It will be supported by IPC by ASHAs, AWWs during the VHND and the RI sessions at the village level, and counseling of parents of newborns about the importance of complete immunization at the facility

level. A new colour coded BCC immunization card (based on the *Indradanush* colour coded RI strategy for ensuring minimum of 5 contacts in the first year) which has been developed and field tested is being proposed to complement the RI campaign.

- **Bal Chetak Strategy for RI:** In addition, a child to community intervention for community mobilization *Bal Chetak* strategy (Alert Child Guardian intervention) will be piloted in one district for increasing immunization coverage. Piloting the intervention in one district will provide the evidence for scale up and for understanding the logistical issues associated with the intervention.

Involving coordination and convergence with the Department of Basic Education, the *Bal Chetak* is a child volunteer (10-14 years) working in pairs to track the immunization status of 4-5 infants in their neighborhood. The *Bal Chetak* will maintain a diary with names of the children, provide a home visit two days prior to the immunization session to inform parents, follow up visit on immunization day to ensure participation by the infant's care giver. The motivation for the *Bal Chetak* is planned through public awards & certificates at the Block & District level. ASHAs, School teachers or village volunteers would be enlisted to provide supportive supervision to the *Bal Chetaks*. See Annexure D for more details.

- **Child Health and Nutrition Months (Bal Swasth Poshan Mah - BSPM):** It is proposed to support the BSPM by IEC campaigns in June & December as in the previous years through extensive IEC and media advocacy efforts on mass media like Television, Radio and Dailies supported by IPC and local media like posters and handbills.

- **School Health Programme:** The programme is being scaled up to 48,000 schools this year. IEC support is being planned for the School Health Programme through wall paintings, handbills for distribution to the students, and non-tearable foam posters on health and hygiene. The Bal swasth cards being provided are budgeted in the programme budget.

Table 4.4: Activities Planned under Child Health Related Campaigns

Inter personal communication HHs and community level	Mid Media / Local media
Household Level • Identification & tracking of beneficiaries for RI through household visit by ASHA per session **Village Level** • VHND - Counseling of pregnant/ mothers of new borns by ANM on importance of complete immunization during ANC / PNC visit **Community Level** • Monthly group meetings for demand generation for RI activities ASHA & ANM as per monthly themes • Saas Bahu Sammelan **Facility Level** • Counselling of pregnant women/ mothers of newborns on RI during ANC, delivery and PNC visits by ANM, FWCs, MO/IC	• Wall Paintings on RI & BSPM: ○ ASHA home ○ Sub Centre ○ PHCs / CHCs ○ District hospitals • Folk performances on Child health and parental responsibility by trained troupes • Rallies by School children for BSPM months • IPC materials for use by ASHA during home visits and group meetings: ○ VHND/ RI handbill ○ Advocacy book for VHSC members • VHND and RI Flex banners • BSPM Posters • School Health Programme Posters, wall paintings and handbills

D. ADOLESCENT HEALTH BCC CAMPAIGN

The *Saloni Swasth Kishori Yojna* (SSKY) was launched by the State Government of Uttar Pradesh under the National Rural Health Mission in October 2008. SSKY targets school going adolescent girls in the age-group of 11-19 years and is being scaled up in FY 2010-11 to over 8000 schools across the state covering approximately 12,00,000 adolescent girls.

The SSKY seeks to address the problem of acute anaemia in adolescent girls through observed oral therapy of providing weekly IFA through the DOTS approach and bi annual de-worming and medical examination of girls. Complemented by monthly sessions for in-school counselling on health, nutrition and hygiene through the Saloni Sabhas, SSKY proposes to bring about sustainable changes in dietary and hygiene behaviors of adolescent girls and increase awareness and knowledge on RH issues.

The Saloni Sabhas have been conceptualized as monthly group counselling sessions at the school covering topics including health, nutrition, how to detect anaemia, healthy food habits, how to build negotiating skills, self confidence and team building, female reproductive organs, personal and menstrual hygiene (including how to prepare homemade sanitary pads), correct age of marriage, and delaying of the first pregnancy, among others. The lecture would be followed by group activity for which there is a monthly provision of Rs 300/- per school. The group activities would cover interactive games, role-plays, demonstrations of recipes, making sanitary pads, hand washing and personal hygiene.

The key behavioral outcomes for the SSKY to be promoted through the monthly Saloni Sabhas are:

1. Increase frequency/ nutritional value of food intake to 3 times/day for adolescent girls
2. Maintain Personal hygiene and menstrual hygiene
3. Delay age at marriage to 18 years for girls and 21 years for boys
4. Delay first pregnancy till woman is 21 years of age
5. Increase detection of symptoms of RTIs
6. Increase treatment seeking for RTIs

Table 4.5: Activities Planned under Saloni Swasth Kishori Yojna

IPC	Mid Media / Local media
Household Level • Reinforcement of behaviors and record keeping by adolescent girls through Saloni Diaries **School Level** • In School monthly counselling sessions on health, hygiene & nutrition through Saloni Sabhas • Weekly IFA through DOTS approach • Biannual medical examination and de-worming by team of medical doctors	• Set of 3 wall paintings on key behaviors related to health, hygiene and nutrition at the selected Saloni school • Saloni sabhas • Saloni Handbills for parental consent / information Materials developed for SSKY: • Teachers Guide for monthly in-school Saloni sessions: ○ ***Session 1:*** *SSKY & Me* ○ ***Session 2:*** *What is Anaemia? What can I do about it?* ○ ***Session 3*** : *Balanced Diet and my role* ○ ***Session 4***: *Self confidence and my role in*

	improving my diet ○ ***Session 5***: *Hand washing with soap after defecation* ○ ***Session 6***: *Female reproductive organs, Menstrual cycle & hygiene* ○ ***Session 7***: *Importance of personal Hygiene* ○ ***Session 8***: *Correct age at Marriage* ○ ***Session 9***: *The underage mothers and the right age for first child* ○ ***Session 10***: *Saloni group, my diary and the change in me.* • Corresponding Saloni Diary for adolescent girls for record keeping and for session review. Press Ad ; Poster
**The communication package including the Teachers guide and the Saloni Diary have been developed by Johns Hopkins Bloomberg School of Public Health/ Center for Communication Programmes under the ITAP project funded by USAID.*	

A detailed facilitation guide for the teachers has been developed along with a capacity building / training plan which is detailed under the programme section on the Saloni Swasth Kishori Yojna. A corresponding Saloni Dairy for the adolescent girls for record keeping and session review has also been developed. An important innovation of SSKY, the diary will also enable the documentation of the process of empowerment in the girls. The materials are being evaluated and field tested in Hardoi and will be ready for scale up in the year 2010 -2011.

E. URBAN HEALTH CAMPAIGN

Urban areas report a high rate of home deliveries and low rates of immunization of children. A significant percentage of the population in the cities of UP live in slum areas, thus are even more prone to sickness and disease. There is an urgent need to connect the services with the demand and publicize the RCH services available at the Urban Health Posts.

Local district specific activities are being proposed to direct the demand to the services. Signages / hoardings at the UHP will be displayed prominently. Local cable channels with strip ads with locations of UHPs, and schedule of services will be undertaken. Additionally, demand will be generated by street plays and IPC by the home visits being proposed through the RI Link workers.

Table 4.6: Activities Planned under Urban Health and RI

IPC : HHs and community level	Mid Media / Local media
Household Level • Identification of clients for spacing/limiting; RI through household visit by RI link worker **Facility Level** • Counselling of pregnant women on PPFP/ RI during ANC, delivery and PNC visits by ANM, FWCs, MO/IC	• Wall Paintings / Hoardings at Urban Health Posts on benefits of small family/ right age at marriage/ NSV/ IUCD • Signages and on-site communication • Handbills for community • Folk performances on FP / IUCD/ PCPNDT / Male participation by trained troupes • Street plays for NSV • Street plays for PCPNDT (district level) • Competitions at Inter/ Degree colleges for PCPNDT •

Chapter 5

Behavior Change Monitoring and Evaluation

What is the difference between monitoring and evaluation?

Table 5.1: Monitoring and Evaluation Components

	Monitoring	Evaluation
Why is it done?	To learn whether activities are being implemented as planned.	To learn whether implemented activities are having the effect they were intended to have.
When it is done?	On a daily, weekly, or monthly basis throughout the life of the project (starting on day 1)	Once or twice over the life of the project/initiative
Who does it?	Everyone	Usually done by a 3rd party
How is it done?	Routine reporting systems are built into communication activities	A special study is designed are carried out
How much does it cost?	Low cost •You need to enter a budget item for monitoring, to be sure that it is adequately supported, or it won't be done properly	Moderate to high cost •This research can cover many needs over a longer timeframe
How are the results used?	With a short turnaround time, monitoring data is used to routinely: •Identify and resolve implementation issues •Modify activities over the course of the activity	With a longer turnaround time, evaluation data is used to: •Measure whether the activity achieved its target •Propose modified activities for the future
What if it is skipped?	Will not be able to say how many activities were completed, how much air time was bought, how many printed materials were distributed, how many meetings were held, and the number of people reached	Will not be able to tell whether all the activities you implemented have had the intended effect.

What is behavioral monitoring?

Behavioral monitoring is often the weakest link in the implementation BCC programmes. The UP BCC strategy provides an opportunity to develop a comprehensive monitoring plan that includes BCC interventions at household, community, health facility and mass media levels. Behavioral monitoring can be defined as regular and on-going monitoring of BCC inputs and health behaviors. BCC inputs

include efforts that are put into the BCC initiative, such as home visits by an ASHA, VHND events, and media activities such as wall hoardings. BCC inputs also include specific BCC messages such as 3 ANC visits for each pregnant woman.

Monitoring of implementation of such a vast BCC plan is necessary for effective implementation of planned activities. Behavioral tracking and monitoring of BCC activities need to be strengthened.
In the PIP 2010-2011, four strategies for strengthening behavioral monitoring and evaluation are proposed:

1. Tracking priority behaviours;
2. Monitoring BCC inputs;
3. Formative research for campaign planning;
4. Systematic evaluation of pilot interventions and innovations.

- **Tracking NRHM Priority Behaviors**

At least 6 of the 14 priority behaviors proposed under the BCC strategy are not being tracked through either SRS or DHLS surveys at the state level. These behaviors will be included in SRS and DHLS surveys or any other surveys. District level functionaries will have access to district level data, which will be available for all the priority behaviors. The following six behaviors will be included in tracking surveys:

1. Stay in the hospital for 48 hrs after delivery
2. Eat three times a day (women and adolescent girls); eat 3-4 times a day (pregnant women)
3. Keep the newborn warm with skin to skin care
4. Wash hands with soap after defecation and prior to feeding child under three years
5. Early detection of TB
6. Empty and dry water containers once a week

- **Monitoring BCC Inputs**

It is important to monitor BCC inputs at the community level. These include home visits, group meetings and community events (*Swaasthya Melas*; *Saas Bahu Sammellan, Godhbharai* ceremony etc.). These inputs will be monitored routinely and will be incorporated into the existing MIS with the help of development partners.

- **Formative Research**

Formative research that can inform media campaigns and community BCC inputs is needed and is being budgeted. This will be initiated at the state level. In addition, a number of formative research studies for family planning are being planned by some of the development partners for urban health. Findings from these will also feed into developing and assessing existing materials. In addition, formative research for maternal and child health will be undertaken to inform the development of the BCC campaigns.

- **Systematic evaluation of pilot interventions and innovations**

The PIP includes several pilot BCC interventions and innovations such as the Bal Chetak strategy for RI. These pilot interventions should have a summative evaluative component with a good study design to enable a systematic assessment of impact. A lump sum of Rs. 25 lacs is being budgeted for monitoring and evaluation, as well as mid term impact assessment of BCC activities under this proposed plan. This will be initiated at the state level.

Proposed Implementation and monitoring processes:

The implementation of activities being proposed in the PIP requires institutional capacity within the NRHM for implementation of the BCC activities, and support by professional advertising agencies for development of mass media and IPC material for the proposed campaigns.

Building BCC implementation capacity at the District and the Block level: To develop the implementation capacity of the Health Education Officers at the block level, the District Project Officers, and the District Community Mobilizers, extensive capacity building courses are being planned. The detailed curriculum of the 5 day BCC course has already been developed by Johns Hopkins University Bloomberg School of Public Health Center for Communication Programmes through the ITAP project. As a first step, over 1000 officers (Div PMs, DPMs, DCMs, BHEOs) will be oriented to the BCC strategy for the state, learn to undertake situational and audience analysis, frame specific BCC objectives at the block level, and develop strategic communication plans. The curriculum will also lay special emphasis on developing monitoring and evaluation skills at the block level for effective monitoring, and quality assurance of the household and village level IPC and community activities being planned in this PIP.

Monitoring mechanisms for BCC activities:

Well planned supervision and monitoring are necessary for large scale implementation of the BCC campaigns and for implementing BCC activities at the community level. The systematic implementation of BCC strategies will be largely dependent on the establishment of effective supervision and monitoring systems.

Detailed campaign implementation guidelines will be provided to the block and district level BCC implementation staff for effective implementation and supervision. Photo verification of large scale community level activities like folk performances, saas bahu sammelans and Tehsil level Gram Pradhan Sammelans will be planned. Photo verification of local media activity such as wall paintings and hoardings will be sought from agency. Post plan evaluation of mass media releases will be sought from media planning agency for evaluation of mass media activity.

Apart from the above, the following monitoring mechanisms will be institutionalized for regular monitoring of BCC activities:

Table 5.2: Monitoring of Output Indicators

No	BCC Output Indicators	Level of monitoring	Frequency	Level of supervision
1.	Number of Home visits implemented / planned	Village Level	Monthly	Block level Health Education Officer (BHEO)
2.	Number of group meetings implemented/ Planned	Village Level	Monthly	Block level Health Education Officer (BHEO)
3.	Number of folk performances implemented / planned	Village Level	Monthly	Block level Health Education Officer (BHEO)
4.	Number of VHND held	Village Level	Monthly	Block level Health Education Officer (BHEO)
5.	Community Notice Boards	Village Level	Monthly	Block level Health Education Officer (BHEO)
6.	Saas Bahu Sammelans held/ planned	District Level	Quarterly	District Programme Manager (DPM)
7.	Tehsil level Gram Pradhan Sammelan held/planned	Tehsil Level	Quarterly	District Programme Manager (DPM)

- **Methods of random supervision:** Methodology proposed to be used for random supervision of BCC includes random surprise checks on work of frontline workers; making household

visits along with ASHA to observe her skills of conducting home visits and counseling and providing supportive supervision; attending group meetings on a random selection basis to observe that these are being conducted according to the themes and protocol decided in the plan; and checking and verifying registration of people attending group meetings periodically.

Chapter 6

BCC Messages for Priority Behaviors

This chapter introduces the reader to the basics of developing BCC messages for the NRHM's priority behaviors. It addresses the characteristics of effective BCC, the process of developing BCC, and examples of BCC campaigns that converge across all media channels - ICP and community events, community mobilization and mass media.

BCC messages are developed based on an existing need identified through the situational analysis, or other analysis. They consider the intended audience, and address barriers to behavior change through the communication.

Characteristics of Effective BCC

1. Developed for the intended audience
   - Messages should be written in the language, and at the level of literacy of the intended audience
   - Messages should include pictures
2. Be motivational and persuasive
3. Be clear and concise
4. Indicate a specific behavior to be taken
5. Highlight a benefit of the behavior that is important to the intended audience

The messages below highlight some of these characteristics, and demonstrate a message promoting one behavior – 3 antenatal care visits – to two different audiences.

Intended audience: women of reproductive age

[Have a healthy baby. See an ANM 3 times during pregnancy.]

Intended audience: husbands

[As a husband, it is your responsibility to care for your wife. Take her to the clinic 3 times during pregnancy.]

Addressing Barriers to Behavior Change

BCC messages should address barriers encountered by members in the community. ASHAs, ANMs, and other BCC functionaries can identify and understand barriers community members encounter to behavior change through their interpersonal communication and community interactions.

The messages below demonstrate how BCC messages can address barriers.

Mother's barrier to behavior change	Effective BCC message by ASHA
["I must care for my other children and can not take my baby to the clinic for immunizations."]	*["Come with all your children to next month's VHND for baby's immunizations, and healthy snacks for your other childfren."]*

The 7 C's of Behavior Change Communication

It is helpful to keep in mind the following when developing effective BCC. Messages are more effective when they

1. Command attention
2. Cater to the heart and head
3. Clarify the need and desired behavior
4. Communicate a benefit
5. Create trust
6. Convey consistency across all messages
7. Call to action (a desired behavior)

Developing and Pre-Testing BCC Messages

For districts and blocks, much information has been provided in the state BCC strategy to develop BCC messages. This includes defining the health topic of focus, the situational analysis, and priority behaviours to target.

Developing BCC messages follows a creative process (Figure 6.1). During this process, BCC messages are most effective when they are developed through a participatory process; that is asking for participation from key members of the intended audience.

Often the most effective messages rely on proven messages already developed at the National or State level, and modifying them to meet the specific needs and context of the community and

environment of the district and block. If national BCC messages have been developed, the language and images can be changed to better appeal to those living in the target community, while still maintaining the desired behavioral action and its benefit.

Following a guide, such as a creative brief (Figure 6.1) can be helpful.

Figure 6.1 Model for a Creative Brief

Drafting the Creative Brief

1. **Intended Audiences** Be specific about who the program wants to reach. The primary audience consists of people that the BCC program wants to motivate to practice a healthy behavior. These usually are the people who are at risk of or who are suffering from a particular health problem. Secondary audiences are people who influence the health behaviors of the primary audience, such as family, friends, and opinion leaders.
2. **Objectives** State what the intended audience should do after they hear and/or see the message.
3. **Obstacles** State the obstacles that can prevent the audience from making the desired change. These might be beliefs, cultural practices, peer pressure, or misinformation, for example. Audience research and relevant behavioral theories can help identify these factors. Focusing on decreasing such barriers to behavior change can help with designing more effective programs.
4. **Key Benefits** State the benefits of the desired behavior for the intended audience. These often appear in the program's messages.
5. **Channels** State which channels and products will carry the messages— for example, television, radio, newspapers, Internet Web sites, posters, flyers, telephone hotlines, peer or client counseling, community meetings, or live entertainment.
6. **Key Message Points** Identify the core information that will be included in all communication, including advertising slogans, counseling messages, and community activities.

Pre-testing BCC messages is a critical step in the process. Pre-testing provides the opportunity to test out the messages developed during the creative stage with members of the target audience to see if they have the desired impact on behavior. Make sure the pre-test audience has same characteristics as the target audience; for example if the message targets bringing babies to VHNDs for weighing, the pre-test audience should include mothers of young children, and not include elder men.

BCC Message Channels

Chosing a channel for BCC messages is just as important as the message itself. It is most effective to use reinforcing or converging channels. An example of an integrated BCC campaign across channels can be found in Annexure E.

Examples of BCC messages using this integrated approach include:

Interpersonal communication and community events

- One-to-one messages communicated by the ASHA, ANM, MPP, or AWW individually or in a group setting, such as a monthly ASHA group meeting

Community Mobilization

- 'Puniya' or spiritual motiviation among community advocates
- VHSC efforts to generate demand for community events or health care services delivered by the ASHA or ANM

Mass Media

- Consistent messages promoting priority behaviors identified in the UP BCC Strategy at the national and state level

An IEC distribution model can be found in Annexure F.

ANNEXURE A: Twenty-Seven Important Behaviors across 10 National Health Programmes

1. Women's Health	**Anaemia**	Eat 3 times a day
		Eat iron rich and vitamin C food daily
2. Maternal Health **3. Newborn Health**	**Ante Natal Care**	Early Registration < 12 weeks
		3 ANC check ups
	Intra Natal Care	Institutional delivery
	Post Natal Care (Mother)	Stay in the hospital for 24 hours 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
	Newborn	Immediate and exclusive breastfeeding within 1 hour
4. Child Health	**Infant / Child <5 years**	Do not apply anything to the cord
		Keep the baby warm; weigh newborn within 24 hours
		Exclusive breastfeeding from 6 months
		Complete immunization / booster / Vitamin A
		Complementary feeding from 6 months 4-5 times in addition to breastfeeding
5. Family Planning	**Spacing**	Delay the first pregnancy
		Increase birth interval to 3 years
	Limiting	Adopt any limiting method after 2 children even if both are girls
6. Tuberculosis (TB)		Early identification of TB
		Continue and complete treatment for prescribed period
7. Vector Borne	**Malaria /** **JE (Japanese Encephalytis)**	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

8. Blindness Control		Seek care if vision is unclear
9. Adolescent Health		Age at marriage, IFA supplementation
10. Hygiene and Sanitation		Hand washing after defecation and before feeding child

Annexure B: Saas Bahu Sammellan at Village / Block

The Saas Bahu sammellan (mass meeting with mothers-in-law and daughters-in-law) can be planned as a local event during VHND/Khushali Diwas. The event could be of approximately 2 hours duration.

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.
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 behaviors/actions expected of the mothers-in-law.
7. Decide if the oath is to be taken with “diyas”, 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

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.

Implementation

1. Welcome and objectives of the meeting

2. Icebreaker: Communication exercise.[3]
3. Tug of war
4. Story/Role play and discussion on need for 3 ANC behaviors
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

Oath taking and wrap up (ensure that the main behaviors 3 ANC check ups and institutional delivery are reinforced during the wrap up session)

[3] Make mixed pairs of mother-in-laws and daughter-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.

ANNEXURE C: Home Visit and Situation Specific BCC by ASHAs

For proper BCC to occur, the ASHAs and ANMs must possess critical communication and assessment skills. These skills include:

1. How to ask questions and assess BCC needs;
2. How to listen;
3. How to diagnose behaviors that require change;
4. How to provide persuasive inputs based on identified client-specific needs

It is important to address specific needs of different individuals. Every household will have different reasons for health problems, and different ideas about solutions that will or will not work for them. These reasons need to be identified prior to provision of BCC inputs. Otherwise "general messages" will be preached without much behavioral change. To move households towards changing behaviors, 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.

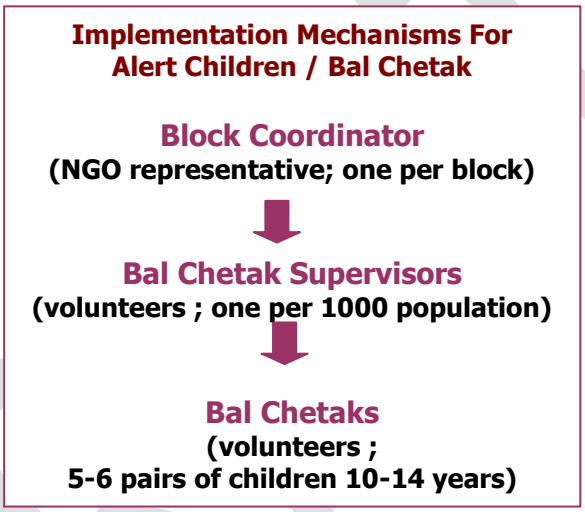
Guidelines for Home Visit

- 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 behaviors are performed or not performed
- Encourage positive/appropriate behaviors
- Identify one or two behaviors that require change in that household
- Address the reasons cited for non performance of the behavior
- Provide options and solutions through dialogue with household members
- Repeat the main behavioral 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

Annexure D: Implementing Bal Chetak Interventions
(Child to community approaches)

The "Bal Chetak" Intervention aims to achieve the NRHM objectives of increasing% of children (12-23 months) fully immunized from 22% to 50%.
The Bal Chetak employs child volunteers to mobilize the communities in which they live. 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 14th November at a public function. The performance of the supervisors of the Bal Chetaks can also be acknowledged at the same function.

Implementation of Bal Chetaks



Bal Chetak Plan for RI Community Mobilization

Using Bal Chetaks for community mobilization for Routine Immunization	
Who is a Bal Chetak	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.
Bal Chetak's role	1. Maintain a book with the names and immunization coverage of average 4-5 infants in their area. 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. 3. Bal Chetak's to check the infant's immunization card during the home visit and mark its current status in their record book. 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.
Bal Chetak's	• Three home visits a month per pair to 4-5 homes with infants

Schedule	a. Home visit 1: 2 days prior to the VHND b. Home Visit 2: Morning of VHND c. Home Visit 3: One day after VHND • Monthly review meeting with the Bal Chetak Supervisor (Fixed time / date / place)
Criteria for Selection of Bal Chetaks	• Child (10-14 years) with good communication skills • Equal numbers of pairs of girls and boys • Child should be residing in the neighbourhood allotted to her/him • Child should be willing to become a Bal Chetak • Child can be selected by either NGO or school based on above criteria only • There will be approximately 5-6 pairs of Bal Chetaks per 1000 population
Bal Chetak Incentives	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.
BCC Materials for Bal Chetak Intervention	• Orientation package for supervisors • Cards for home visits • Home calendar • Bal Chetak record keeping book

Supervision Plan for Bal Chetaks

Bal Chetak Supervisor	
Coverage Area	One supervisor for 1000 population (5-6 pairs of children)
Criteria	• Should be a resident of the village • Can be a Samiti member, Shiksha Mitra, youth volunteer, retired school teacher, NGO worker etc.
Responsibility	• The supervisor works in a voluntary capacity • Should be able to select, train and provide continuous guidance. • Supervisor has to allot areas and keep track of new births from ASHA and allot them to Bal Chetaks. • Maintain a record of the overall immunization coverage in the village

"Indradhanush" – Colour coded BCC strategy for RI for Bal Chetaks and Community Mobilization

BCC initiatives in RI pose a challenge because of the number of vaccines, varying doses per vaccine and differing time intervals between doses. 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.

Colour Coded Scheme for Routine Immunization

Colour Coded BCC Strategy for RI for Bal Chetaks / Community

Key Behavioral Focus : *5 contacts per year for complete immunization of an infant*

- 1st Contact (Violet/Baingani): BCG, zero polio
- 2nd Contact (Blue/Neela) DPT1
- 3rd Contact (Cyan/Asmani) DPT2
- 4th Contact (Green/Hara) DPT3
- 5th Contact (Yellow/Peela) Measles

Booster:

- 6th Contact (Orange/Narangi) DPT Booster, JE, Polio
- 7th Contact (Red/Lal) DT Booster at 5 years

Community level inputs:

✓ Notice Board: VHND schedule
✓ One group meeting per year by ASHA on RI

ANNEXURE E: Example of an Integrated BCC Campaign

Health Focus: Maternal and Newborn Health

Overall Objective: To reduce maternal mortality from 517 per lakh live births to less than 360 per lakh live births by 2012

Behavioral Objectives

1. To increase early registration (< 12 weeks) from 25.7% to 50% by 2012
2. To increase 3 ANC check ups from 26.3 to 50% by 2012

Integrated BCC Campaign

Barriers	**Interventions**	**Strategy**	**Activities**	**Workload**
Lack of social norm of early registration Added expenses in terms of fees, medicines and transport. Belief that getting womb examined by a woman of lower caste would lead to a bad omen. Lack of perceived need as previous deliveries were normal without having ANC check ups44 Gender: Low autonomy and status of women in Uttar Pradesh45	**State Level: (Mass Media Channels)** TV o Local Cable TV. Daily spots during 4 months o Short films "CD Spots" on specific issues Radio spots minimum of 3-4 spots a day on Primary Channels & FM **Community Level: (Counselling / Group Meetings)** 2 meetings on ANC in a year – one by ASHA and one by ANM VHND or Khushali Diwas o ANC service provision during VHND o TV Spot / Audio visual spots /Posters for VHND	**Strategy:** Focus on the concept of "puniya" (spiritual merit) 46 to the family, pradhans and providers if maternal and newborn lives are to be saved. Specific actions to be promoted o Early registration o 3 Ante Natal Checkups Strategy 1b: Promote male responsibility for early registration and 3 ANC visits.	Development & Production & distribution of campaign materials like TV, Radio, audio visual films, Local media & Print materials like Posters, Wall Painting, Hoardings, IPC tools. Preparation of Guidelines & IPC tools on MNH for home visits & Group Meetings by ASHAs Listing of eligible women for Home visits & Group meetings	3 home visits x 30 pregnant women/ASHA = 90 ANC visits per ASHA per year 2 ANC Mtg/per year x 1,30,000 ASHA areas (260000 mtgs on ANC) One VHND /month x 52047 villages = 52047 VHNDs per month

ANNEXURE F: IEC Distribution Guidelines

"How to Organize IEC Material Distribution for Maximum Impact"

Prior to distribution of IEC materials

- Suitable communication strategies should be identified prior to the design of materials to achieve the highest impact on the target population using up-to-date scientific data. The distribution media can include any combination of mass media, printed materials, and outdoor media placement.

- IEC materials have to be developed through **evidence-based** research and situation analysis of the population and the disease in order to determine target audiences, appropriate health prevention messages, and strategies of distributing the materials.

- Unified images, branding strategies, and incorporated messages serve as the best approaches to create unity between the various communication activities. They allow the target audiences to build up knowledge, understanding, and protective action over time.

- All BCC campaigns should maintain **credibility and trust**, by providing practical, up-to-date, and accurate information, implemented and reinforced in coordination with authorized sources such as government spokespersons, international health authorities, health care professionals, and community-based institutions.

IEC Material Distribution guidelines

- The message load (# of messages/ indicators) of a health promotion program is usually greater than any single IEC material can handle. Thus, the success of health promotion interventions depends on an adequate, creative and efficient mix of various IEC materials. A strategic combination of the different IEC materials gives the health promotion intervention the opportunity to have a positive impact to adopt and continue protective behaviors.

- Refer to the **UP communication strategy plan** to understand the comprehensive distribution strategy prior to disseminating IEC materials, since it is pre-determined who this material should be distributed to. Making sure that IEC materials reach their target audiences increases the likelihood that the material will have an impact on behavior change on its intended audience

- Having a comprehensive distribution plan makes it easier to monitor and evaluate the usefulness of IEC materials and measure impact on audiences.

- Instructions and suggestions for distribution should be supplied along with the materials prior to dissemination to give partners a better sense of their target audiences, their habits, and their daily routines (expect to receive these in coming IEC shipments).

An effective distribution of IEC materials is characterized by:

- Directing attention to the message being delivered through innovative approaches.
- Involving the audience in a range of emotional experiences to motivate them to change.
- Demonstrating the message in language and situations that the audience can understand and readily recall.
- Communicating a benefit and motivating the audience to adopt the new behavior.
- Creating trust between information providers and the audience.
- Delivering the message in a consistent, appropriate, relevant manner.

Audience

- Understand who the target audiences are. Each group has different levels of literacy and may have different behavior patterns and service needs. IEC materials are designed for **specific populations,** therefore, should be distributed in the same fashion.

- Take into account the cost associated with each one of the IEC materials, and to whom they will be targeted the best. Who will make the best use of them?
    - Materials for home use: brochures, bookmarks
    - Materials for health center use: posters, clipboards, brochures, desk top calendars
    - Materials for community display: posters, stickers, calendars
    - Materials for mass media: TV and radio spots, articles in newspapers.

- Distribution activities should always keep these tips in mind to avoid wastage and ensure maximum IEC impact.

Health workers/AWWs/ANMs/ASHAs

- **Training** community-level implementors involved in the distribution of the IEC material is essential to provide the audience with the correct and proper messages they need to know, since health workers are the primary source of information. It is also important to avoid overly-crowded distribution events and seek opportunities that allow for increased dialogue and exchange with target audiences.

- **Communication** with the audience is essential. Community-level implementers should not just hand over the flyer/brochure, but should go through the information contained in the material carefully. IEC materials distribution should preferably be carried out by a health worker to influence behavior change.

- Implementers should be trained to speak loudly and clearly, and use familiar words to ensure that those listening understand what is being said. They should also be trained to encourage the audience to ask questions. IEC materials designed for health workers should be handed to them during their training for maximum impact.

Audience involvement

- Integrate distribution of IEC materials with the design of activities aimed at mobilizing communities through networks that have a particularly strong presence in rural areas. This can be done through: interpersonal channels, mass media channels, and community-based channels. Most effective campaigns combine mass media with communities and individual activities and are supported by an existing community and national structures..

- Multimedia campaigns are most effective when mass media and popular traditional channels are used in combination with distributing IEC materials, along with person-to-person interactions, reaching more people in the community. Therefore, IEC distribution should be timed to match the airing of mass media output.

- Getting the audience involved encourages them to keep the brochure, communicate with their health providers and educators, and share information with friends and family

- People learn new behaviors best when they can put what they are learning into practice and when they feel they are learning behaviors that are useful in various aspects. New behaviors are also adopted when people receive feedback and are rewarded for doing well, especially when they are taking initiatives to protect themselves, their families, and their communities.

- Develop linkages and collaborations with different local authorities and groups who can help in distributing the materials to the right audiences. In addition, understand the distribution patterns in surrounding regions to ensure that yours are complementary and not redundant.

Timing and locations

- The **timing** of the campaign helps determine its effectiveness in targeting the right audience. Take advantage of local holidays and festivals to disseminate messages for inaugural events, making sure to address the right audience and channels for distribution (e.g. disseminating materials targeted for women at markets at times when women are shopping for food).

- Posters and wall charts should be displayed in public areas so that the individuals can see and read clearly. Related topics and items should be displayed on or with the appropriate and corresponding posters in order to ensure clarity and continuity and to avoid ambiguity and confusion (pairing of relevant IEC materials).

- **Location** of IEC material distribution, where the target audiences are found, and what public or private events they attend are essential. This depends upon the extent of access the audience has to a specific location, time, space, etc. Situational analysis prior to distribution provides this data.