Social and Behaviour Change Communication (SBCC) Strategy for RMNCH+A in Rajasthan

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PREFACE

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Communication is the core substance of every activity we experience in this world. The interaction between all living things starts with communication, from cradle to grave, from womb to tomb. Success of interaction depends on how strategically the message has been delivered and the communication has been established yielding desired outcome. Government programs also experience the same phenomenon and are required to go through the same test of effectiveness of the communication. Outcome of a planned activity is directly proportional to the effectiveness of the message which in turn depends on the strategy and ways adopted to deliver the information up to the beneficiary groups and individuals.

In the year 2013, the government of India launched its RMNCH+A program encompassing a 5x5 matrix to provide continuum of care to the newborn, child, mother and adolescents. The concept is strongly based on the premise that the health of an individual, across all the stages of life, is interlinked. In a way, the key to success of this program lies in an effective integrated Social and Behavioral Change Communication strategy. Under the GAVI-HSS supported partnership between SIHFW and UNICEF, Rajasthan, efforts are being made to strengthen communication strategy to improve Interpersonal Communication between service providers and the community to bring about the desired social and behavior changes promoting optimal utilization of services and resources.

In collaboration with UNICEF, SIHFW has developed a Social and Behavior Change Communication (SBCC) Strategy document on RMNCH+A with a view to provide leading directives; like what is the key set of capacity building interventions, why a field worker

requires to be effectively functional and how to do so, for the functionaries working at grass roots and at middle level of health systems. All elements of RMNCH+A strategy such as identification of determinants of practices or behaviors, prioritizing those amenable to change and having the greatest impact on maternal and child health and survival, promoting set of messages in practices related to key RMNCH+A areas have been covered in the SBCC strategy. The document also emphasizes on importance of identifying the key stakeholders whose behaviors can impact RMNCH+A indicators.

The strategy document is also expected to be beneficial for policy makers, administrators, state and district level health and communication officials to understand what support is further required at various levels to yield indicator based outcomes.

The guidance and support of Shri Neeraj K. Pawan, Director IEC has been the main driving force in the development of this document. The inputs from multiple stakeholders including officials of Medical & Health Department, NHM, ICDS, UNICEF, UNFPA, Save the Children, NIPI, Jhepigo, IHBP, PSI, Global Health Strategies and of SIHFW have nourished each and every layer of this document.

Various communication approaches linked to key stakeholders at service and community levels have been identified in this document. This may not be exhaustive and the strategy document is open to amendments.

What we care the most is whether our work would inspire promotion and adoption of healthy behaviors among the targeted population; hence the document is open for valuable suggestions of the readers and users.

Sincerely yours,

(Dr. M. L. Jain)

Acknowledgement

The Social and Behaviour Change Communication (SBCC) Strategy for RMNCH +A in Rajasthan has been developed through a series of consultations with experts and key programme officers of the State Program Management Unit, State IEC bureau, Government of Rajasthan, State Institute of Health and Family Welfare and UNICEF Rajasthan.

We are thankful to the guidance and leadership provided by Principal Secretary Health, Mission Director, National Health Mission, Director IEC, Director RCH and Project Director Immunisation, who have guided and facilitated this process.

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There are many others who have contributed to this and naming all of them is not possible but their advice is sincerely acknowledged.

This strategy was developed under the overall guidance and unstinted support from Mr Samuel Mawunganidze , Chief, UNICEF Rajasthan and Dr M L Jain, Director SIHFW.

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Abbreviations

AHS	Annual Health Survey
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ARSH	Adolescent Reproductive and Sexual Health
AWW	Anganwadi Worker
ASHA	Accredited Social Health Activist
BEmOC	Basic Emergency Obstetric Care
CHC	Community Health Centre
CM&HO	Chief Medical and Health Officer
CTA	Call to Action
DLHS	District Level Health Survey
FP	Family Planning
FRU	First Referral Unit
GoI	Government of India
HBNC	Home Based Neonatal Care
HPDs	High Priority Districts
ICDS	Integrated Child Development Services
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
IUCD	Intra-Uterine Contraceptive Device
JSSK	Janani- Shishu Suraksha Karyakram
MCH	Maternal and Child Health
MCHN	Maternal and Child Health Nutrition

MDGs	Millennium Development Goals
NFHS	National Family Health Survey
NMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
ORS	Oral Rehydration Solution
PC&PNDT	Preconception and Prenatal Diagnostic Techniques
PCTS	Pregnancy and Child Tracking System
PHC	Primary Health Centre
PNC	Postnatal Care
PPIUCD	Post partum Intrauterine Contraceptive Device
RI	Routine Immunization
RMNCH+A	Reproductive, Maternal, Newborn, Child Health and Adolescence
RTIs	Reproductive Tract Infections
SBA	Skilled Birth Attendant
SNCU	Sick Newborn Care Units
TFR	Total Fertility Rate
WIFS	Weekly Iron and Folic Acid Supplementation

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1. Executive Summary

There is increased recognition that health care practices and health behaviour are a key to prevent significant proportion of maternal, neonatal and child death. An integrated, evidence-based Social and Behaviour Change Communication (SBCC) Strategy, using the life cycle and continuum of care approach is critical in addressing the barriers and enabling adoption of key behaviours and practices at the home, community and facility levels. The present strategy document focuses on the five themes-life stages of RMNCH+A for behaviour change.

- The five life stages are Reproductive Stage, Maternal Stage, Neonatal Stage, Child Stage and Adolescent Stage.
- Corresponding to these activities, 16 indicators have been identified for monitoring the progress and improvement of interventions on a continuous basis.
- An objective methodology was adopted to develop this document. In order to take benefit of the experience of development professionals, implementing partners and academicians, core groups were constituted for deliberation on communication strategy for each of the life stages.
- In addition to it, all available secondary literature in the form of documents- strategy document on RMNCH+A, existing IEC strategy, records- PCTS, reports- CTA, situational analysis of districts, bottleneck analysis, KABP on continuum of care, rapid assessment and findings of health surveys like DLH-3, NFHS- 3 and AHS was analyzed to develop an understanding of the situation.
- This document includes situation analysis with respect to the desired behaviour for each life stage, the current status of behaviours and barriers faced at individual, family, community and institutional level

- It was found that most of the audiences were aware of the desired behaviour but were not practicing it due to the various barriers. Based on this analysis, mass media-electronic and print and mid media-street plays is proposed to be used in a limited way to generate awareness on health issues and to strike an emotional cord with the target audience.
- **Inter Personal Communication** (IPC) has been proposed for counselling for specific behaviours to be practised by the target audience to address the barriers so that behaviour change is facilitated. **Social mobilization** will be used to seek community participation and involvement for creating an enabling environment. **Advocacy** would be carried out with policy and management level key officials for policy level changes and with key influencers to motivate the community for practising desired behaviours.
- The practice of the desired behaviours is also dependent to a great extent on the facility-based infrastructure, supply and most importantly facility-based care. The health providers could be instrumental in observance of the critical behaviours at the facility. The communication strategy emphasises on this window of opportunity and includes the institutional level behaviours which could be taken care of by the health staff. For instance, while institutional deliveries have increased, the behaviours which are to be initiated at the facility level have not taken place. While 74.4 percent deliveries occurred in an institution (AHS, 2011-12), only 50 percent of the children were breastfed within one hour. This shows that the health providers at the facility need to be oriented on their role regarding promoting of the desired behaviours.
- In this context, the SBCC strategy proposes to develop **Standard Operating Procedures** (SOPs) for health staff for

each of the behaviour where compliance is to be ensured like initiation of breastfeeding, colostrum intake, kangaroo care, motivating for PPIUCD or postpartum sterilization.

- Using the strategy proposed above, key messages addressing the specific barriers for home-based behaviours and communication tools have been proposed.
- The existing platforms of VHSNC meeting, MCHN Day, Village contact drive, mobile vans for remote and inaccessible areas will be used for promoting the desired health care practices by community participation. For implementing and monitoring the interventions, a roll-out mechanism is proposed.

The roll-out mechanism could be understood in terms of following sub-heads:

- **Planning and Implementing Structure:** The existing IEC Bureau has limited human resources. Out of 443 sanctioned positions, only 47 positions are filled, many of the positions have not been filled from years and they have become defunct.

  To strengthen the implementation structure and facilitate proposed communication interventions, the following are recommended to be instituted and initiated at the state, district and block level:

  - Constitution of SBCC coordination committee under the chair person ship of Principal Secretary, Medical and Health by involving all the Directors and PDs with Director, IEC as Member Secretary.
  - Establishment of Communication Resource Hub at state level
  - Awarding the role of mentor for capacity development for implementation of SBCC interventions to SIFHW

- Advocacy for devoting two-days for MCHN Day; VHSNC meeting- with focus on developing action plan for ensuring participation in MCHN day to be conducted a day prior to the actual MCHN day
- Preparation of capacity development plan and identification of resource agencies for outsourcing its implementation
- Prioritizing the essential institutional support required for implementation of SBCC
- Assigning of responsibilities to development partners and NGO for various identified areas
- Establishment of monitoring system for implementation of SBCC activities in the State
- Preparing implementation plan for the areas where all three workers are not in place

- **District Level:** ASHA facilitators at the district level have been re-designated as District IEC Coordinator. They will be responsible for ensuring the implementation of the activities in the district. In addition, SIHFW can develop its monitoring team or outsource the monitoring work to some agency.
- **Block Level:** Block ASHA Facilitators would oversee the implementation of SBCC intervention at the block level.
- **Village level:** The ANH, ASHA, Anganwadi Worker (AAAs) will be responsible for implementation of SBCC intervention at the village level. These activities would be monitored by involving community members, like VHSNC members. The health facility incharge would also be involved for handholding/support of the frontline workers.
- **Assessment of existing communication material:** A detailed assessment of all available tools of communication

is to be carried out. The communication materials which are relevant to the target audience could be retained; the ones which do not facilitate in pushing the audiences to the next stage of behaviour change by addressing the barriers could be discontinued.

- **Development of new Communications material:** Communication materials are to be prepared with specific messages for specific segments of audience. The barriers to be addressed on priority would be identified and messages and communication material would be accordingly developed. Different themes for awareness generation using mass-media, mid-media-using edutainment approach are to be developed. The operational aspects of village contact drives could be reworked to get better results. Theme-based activities of the meetings to be organized on MCHN Days needs to be prepared. SOPs to be used by health facility staff also needs to be developed.
- **Capacity building of the implementers:** Major emphasis needs to be given on capacity building of the implementers of behaviour change communication intervention. The communication interventions would be implemented by **three As- ANMs, ASHAs and AWWs at the home and community level** and by **health staff at the facility level.** Since IPC, social mobilization and advocacy along with use of various tools is being used as key communication strategy, capacity would be built on conducting counselling sessions, use of communication tools like- information brochure, flip book, games, puzzles, Z cards etc, negotiation and networking skills.
- **Coordination and convergence for implementation:** Different departments need to work in coordination and convergence. The key departments which need to work together are health department, department of women and

child, water and sanitation, rural development, and education department. The combined and coordinated efforts could bring huge changes as the messages would be in sync to each other and will act as reinforcers. In addition, support of staff of the related departments would be sought for addressing institutional level barriers in the form of handholding, monitoring and the front level workers.

- The interventions will be implemented in a phased manner. The blocks have been categorized as low or better performing so that targeted interventions could be implemented in most vulnerable blocks and gradually expanded to other areas.
- Detailed time line for 24 months is included in the document which list out different activities to be performed under each phase. Monitoring formats to be used by the officials have been prepared. The same could be filled by the immediate supervisors and monitoring teams and analyzed to suggest timely corrective measures. After 12 months of implementation, a rapid assessment is proposed to assess the effectiveness of the SBCC interventions.

2. Situation Analysis

2.1 Background to RMNCH+A

The RMNCH+A strategy is holistic in design encompassing all interventions aimed at Reproductive, Maternal, New Born, Child and Adolescent Health under one broad umbrella. It was rolled out by Government of India in 2013. It focuses on the Strategic Life Cycle Approach and is based on the Continuum of Care Concept. The strategy promotes and provides for inter-linkages between different interventions at various stages of the life cycle and facilitates linking of child survival to other interventions such as reproductive health, family planning, maternal health. The approach is based on the strong premise that health of an individual across the life stages is inter-linked. It recognizes that reproductive, maternal and child health cannot be addressed in isolation as these are closely linked to the health status of the population in various stages of life cycle. The health of an adolescent girl impacts pregnancy while the health of the pregnant woman impacts the health of the newborn and the child. The figure below, adapted from UNICEF shows the different life stages with respect to continuum of care.

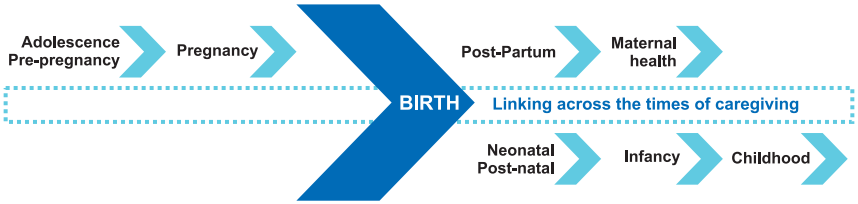


Figure 1.1 Life stages with continuum of Care

Under Continuum of Care approach, there are two dimensions, (1) stages of the life cycle and (2) places where the care is provided. These together constitute the 'Continuum of

[1] ***Source:*** *Ministry of Health and Family Welfare, Government of India; "A strategic approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India: For Health Mother and Child"; January, 2013.*

Care.' This Continuum of Care approach of defining and implementing evidence-based packages of services for different stages of the lifecycle, at various levels in the health system has been adopted under the national health programme. The 'Plus' in the strategic approach denotes the (1) inclusion of adolescence as a distinct 'life stage' in the overall strategy; (2) linking of maternal and child health to reproductive health and other components (like family planning, adolescent health, HIV, gender and Preconception and Prenatal Diagnostic Techniques (PC&PNDT); and (3) linking of community and facility-based care as well as referrals between various levels of health care system to create a continuous care pathway, and to bring an additive and synergistic effect in terms of overall outcomes and impact.

The overview of the key RMNCH+A interventions as a 'continuum of care' is provided in the figure below.

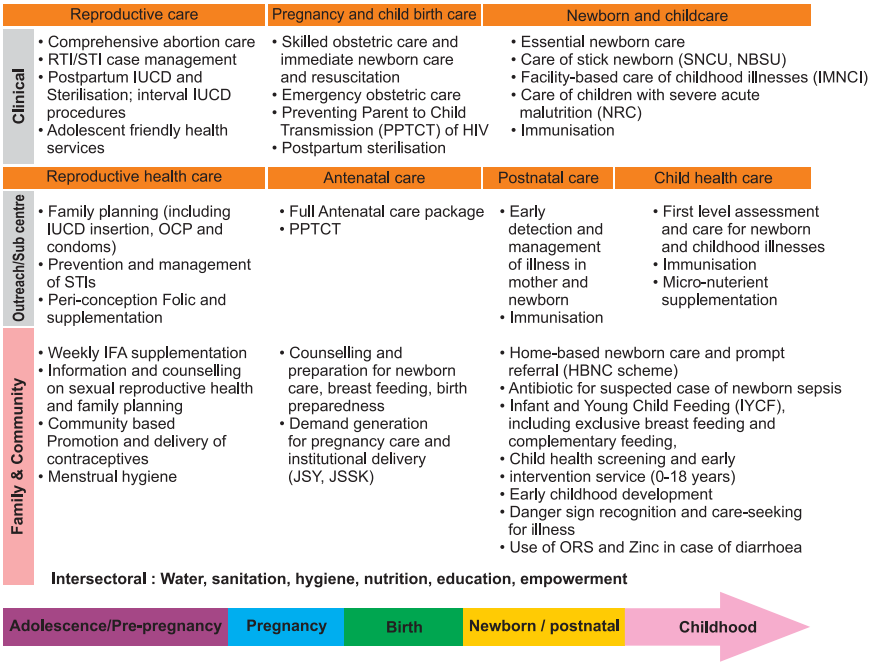


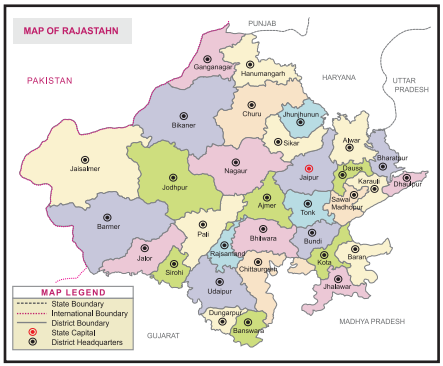
Figure 1.2: Continuum of care across life cycle and different levels of health system

The RMNCH+A strategy is built on the need for prioritizing high impact interventions across the five thematic areas. The five themes are the five areas of RMNCH+A and they have been further broken down into five implementable activities. This has been done to provide services which are of high quality and also which could be measured. The five themes are Reproductive health, Maternal health, Neonatal health, Child health and Adolescent health; the expected activities are elaborated in the 5*5 matrix as Annexure 1.

An integrated, evidence-based **Social and Behaviour Change Communication Strategy**, based on the life cycle and continuum of care approach is critical in addressing the adoption of key behaviours and practices at the home, community and facility levels in order to bring down maternal, neonatal and child deaths. The present strategy document on social and behavior change communication focuses on these five themes. The situation with respect to each theme has been presented below to give a holistic picture of the health situation in the state with special focus on high priority districts.

2.2 Status of Key Health Indicators: Rajasthan

Rajasthan is India's largest state in terms of geographical area. It is located in India's west-central interior and is home to over 68 million people, almost 50 percent of whom are under the age of 18 years (Census 2011). The State has 33 districts, 248 panchyat samities and 44795 revenue villages (Census, 2011). It prides itself on a rich cultural heritage, the people here are known to value long-held beliefs, customs and traditions.



Rajasthan has seen an improvement in reduction of Infant Mortality during last decade with a decline of IMR by 27 Points in 10 years from 79/1000 live births in 2001 to 52 live births in 2011. However pace of decline is not enough to achieve either Millennium Development Goals or XI Five Year Plan Goals. A detailed analysis of the causes, timing and reasons for still such a high Infant Mortality Rate and also what are the opportunities available which can facilitate to expedite the process of Child Survival and Development in Rajasthan are highlighted below:

- Major contribution in decline in Infant Mortality in Rajasthan is seen in the time period of 28 days to 1 year- which has reduced from 32/1000 live births in 2001 to 15 /1000 live births in 2010 (Reduction of almost 2 points per year)
- With effective implementation of Community Home Based programme now decline in the mortality amongst children between 7-28 days also has started showing a decline since 2008 onwards which was almost stagnant for last 5 years.

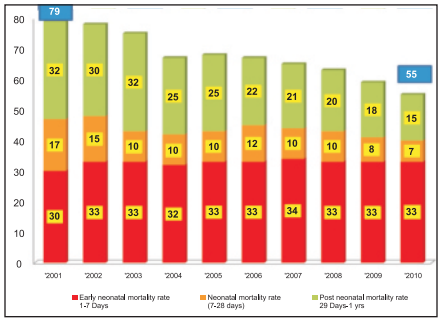


Figure 1.3 : Graph-Neonatal mortality rate

- Delivery and the level of institutional deliveries has gone upto 70% in 2009-10, however the death rate amongst Newborn in First Week of life has not changed since 2001 even by a single point. This is an indirect pointer toward quality of services during process of labour (delivery of child) and immediately thereafter.
- Apart from the time dimension geographically also there

are disparities in the state from one district to another district. Districts having highest IMR in Western and Southern part of Rajasthan are two to three time higher than the Districts with lowest IMR in the State. Incidentally the southern districts of Rajasthan have greater than 70% of State's Tribal population and greater than 50% of State's BPL population. Southern district bear multiple deprivation impacting on realisation of rights of children and have much lower service providers as compared to the state average.

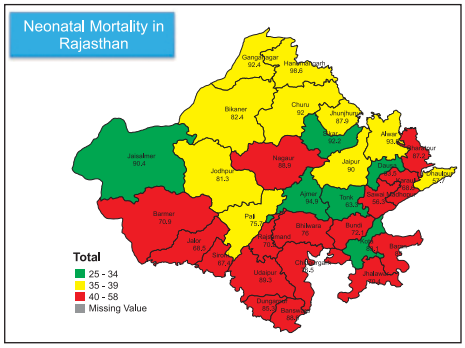


Figure 1.4 : Graph-Neonatal mortality

- Apart from the New-born death, causes of deaths amongst children between one month are primarily due to pneumonia (20%) and Diarrhoea (13%). Under-nutrition contributes to around one third deaths indirectly and around 2% deaths directly to under 5 mortality.
- Similarly for Under-nutrition two critical points along the life cycle are crucial where continuum of care is not seamless. These two points are i) 28 weeks of gestation to the time of birth (as more than 50% of weight is gained during the last trimester of pregnancy ii) Time of complementary feeding which is around 6 months. This is the time of transition from exclusive breastfeeding to complementary feeding and during this transition, child develop diarrhoea and respiratory infections, most of them are not managed and each episode of infection lead to around 10% weight loss of child. Child during this crucial window of 6-9 months get less food in terms of quantity and frequency which further reduces during illnesses.

Analysis of data and past performance of health programmes reveal that Rajasthan has potential to reduce Infant Mortality Rate at the rate of 7-9 points per year. In view of the above the following 7 points are considered as priority areas for next two years under NHM for reduction of 7-9 points in IMR in the State.

2.3 Strategic Priority Actions in Rajasthan

A total of 7 points ranging between -12 weeks to +12 months have been prioritized for taking action in Rajasthan. They are:

1. **Pregnancy 28 weeks onwards (-12 Weeks)**

- Focused ANC with special Emphasis on 28 Weeks onwards

2. **Mother: During Labour, Delivery and First Month of Life of Infant**

- Ensure Quality of Obstetric Care and Immediate Postnatal Care Including promotion of Early Initiation of Breast Feeding: Colostrum feeding
- Ensure Quality of Facility Based New-born Care
- Ensure Quality of Home Based New-born Care including promotion of Exclusive Breast Feeding

3. **Infant: One Month to 12 Months of Life**

- Age Appropriate Immunisation
- Timely age appropriate complementary Feeding
- Management of the Childhood Illnesses (ARI and Diarrhoea)

4. **Pre-pregnancy phase(– 12 Weeks) to Infant(12 Months of Life)**

- Denominator Based Monitoring with special Focus on most Deprived Groups

State Action Plan

The State Action Plan has been developed to achieve the above set goals in a timely manner and to expedite the process of improving survival of new-born and woman in the state. Some of the strategic actions call for systemic changes in the health system, transformation of actions of managers and administrators at various levels, some actions call for attention of service providers at different levels-Household level, outreach-MCHN session site, facility level and some are pertaining to involvement of community members and private service providers.

Continuum of Care: Service Delivery Platforms

Home Based Care: This is a service delivery platform which has a potential for ensuring counselling during antenatal care visits or during postnatal care visits. This also provides an opportunity to counsel women for institutional delivery, early initiation of breast feeding, exclusive breast feeding, age appropriate immunisation, age appropriate complementary feeding. In the present system, ASHA is providing the home based care services and also mobilises women for ANC and Immunisation services, institutional deliveries etc.

Community Out-reach Care: This is another service delivery platform which has a huge potential to link the communities with the service providers. Quality of micro-planning, community mobilisation and denominator based monitoring and quality of counselling will be ensured during the MCHN sessions.

Facility Based Care: Quality of services provided through facilities is the critical gap in ensuring the seamless continuum of care. State has introduced mechanisms for quality assurance care provided through the District Hospitals and Sub-district Hospitals. Quality Assurance will be monitored through Report cards which would be issued on a periodic basis to be

reviewed at the highest levels of state health department cadres. Tracking of survival of status of new-borns and mothers would be ensured on a real time basis.

District, block and sub-block level interventions: Capacity building plans of the Service providers at district, block, sub-block level along with supervisors is being undertaken on a priority basis along with performance linked incentives to frontline workers.

Improving Demand of Services

Barriers to health service utilization amongst communities, is not only related to access, availability or quality issues but also to the demand side. These barriers to services utilization by communities are not only related to social norms governing individual and societal behaviors and practices but also prevailing socio-economic factors which can enable or hinder promotion of positive behaviours leading to the adoption of health practices in the continuum of care of mother and child. An equity approach in selecting, implementing and monitoring of high impact RMNCH+A interventions and high impact behaviours in Social and Behavior Change Communication (SBCC) will ensure that vulnerable groups and marginalized populations are reached for desired changes.

Based on life cycle approach (RMNCH+A), 16 indicators have been identified for monitoring the progress and improvement of interventions on a continuous basis. The indicators will help in fixing the responsibility and for initiating necessary corrective action. A change in these indicators will depend on change in behaviors.

High Impact Behaviors

Based on the analysis of gaps in the continuum of care for mother and child there are 8 critical behaviours contributing to reduction in maternal mortality and neonate and infant

mortality . These behaviours have been selected for intervention in the SBCC strategy in the RMNCH+A framework.

Behaviors selected

Behavior 1: Increasing the proportion of deliveries that occur in a facility and mothers who have access to basic emergency obstetric care (EmOC).

Behavior 2: Increasing the proportion of safe deliveries at home (including a skilled birth attendant, clean delivery, birth preparedness and a care-seeking plan in case of complications and/or emergency).

Behavior 3: Increasing the uptake of preventive postnatal care services for newborns and mothers (including clean cord care, immediate breastfeeding and early follow-up of the mother and child).

Behavior 4: Increasing the practice of skin-to-skin care (STSC)/Kangaroo Mother Care (KMC) for newborns.

Behavior 5: Increasing the practice of early and exclusive breastfeeding of infants during the first six months of life.

Behavior 6: Increasing the proportion of children (6-23 months) who receive appropriate complementary feeding (solid or semi-solid food).

Behavior 7: Increasing the uptake of postpartum family planning methods, including the Lactational Amenorrhea Method (LAM), to adequately space births.

Behavior 8: Increasing the rate of compliance for recommended schedules of child immunization.

The programme monitoring targets in RNMNCH+A across the life cycle correspond to practice of these behaviours at household, family, community level leading to increase in coverage and uptake of services at the outreach and facility level.

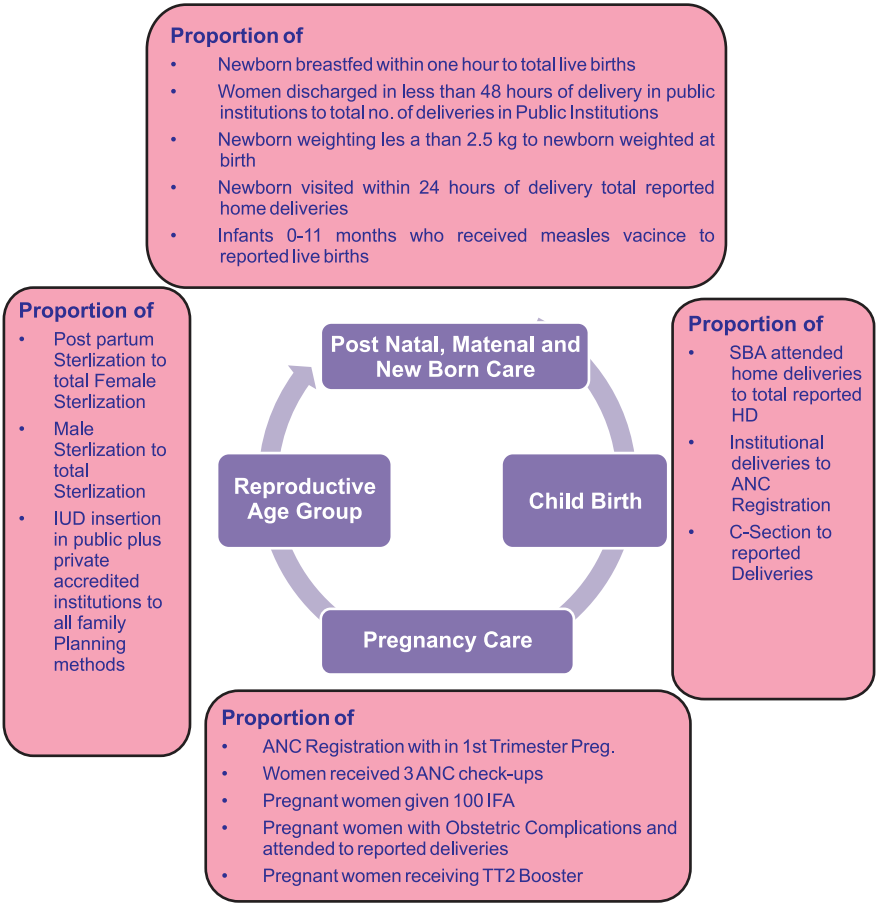


Figure1.5: RMNCH+A:
Program Monitoring Indicators across the Life Stages

The status of these high impact behaviors for key parameters for high priority districts (HPDs) is presented in table 1.1. The identified 10 HPDs are not the ones which are performing below the expected level across all 16 parameters, however, underperformance is observed for most of the parameters.

Table 1.1: Status of the High Priority Districts on 16 dashboard indicators

S. No	Dashboard Indicators	10 High Priority Districts **									
		Banswara	Barmer	Bundi	Dholpur	Dungarpur	Jalore	Jaisalmer	Karauli	Rajsamand	Udaipur
1	ANC Registration within 1st Trimester	42.41	43.44	60	39.49	55.64	39. 2	43.03	54.33	54.33	52.22
2	Preg. women received 3 ANC check-ups	68.55	55.33	72.56	48.63	72.8	63.92	55.7	68.14	62.82	74.92
3	Pregnant women given 100 IFA	64.98	69.13	92.45	65.97	86.72	81.4	100.58	80.78	99.16	102.92
4	Pregnant women with Obstetric Complications and attended	3.29	1.01	6.9	8.47	6.2	14.88	10.31	2.9	2.64	3.51
5	Pregnant women receiving TT2 or Booster	88.29	74.93	84.54	75.57	85.68	80.24	74.42	80.87	81.41	83.95
6	SBA attended home deliveries	46.27	81.73	51.95	27.66	74.56	44.78	42.28	44.87	46.23	82.53
7	Institutional deliveries	74.32	53.17	79.49	76.71	78.16	79.38	67.09	74.51	68.01	61.65
8	C-Section	4.62	1.28	1.18	1.8	2.82	2.43	0.52	2.36	3	8.38
9	Newborns breast fed within 1 hour	96.18	90.95	92.52	99.46	86.53	99.03	93.81	97.77	93.12	89.32
10	Women Stay 48 hrs and more after delivery in public institutes	83.03	83.08	92.46	99.87	97.02	67.79	88.94	98.55	95.45	69.56
11	Newborns weighing More than 2.5 kg	54.68	82.39	71.87	87.35	69.88	58.54	46.94	83.86	45.36	71.21
12	Newborns visited within 24hrs of home delivery	58.47	87.93	53.25	82.81	74.16	86.59	63.25	80.29	74.68	74.26
13	Immunization of Measles	76.11	68.55	90.11	73.94	81.58	82.84	84.18	77.2	96.13	86.94
14	Post-partum sterilization	4.5	0.56	0.99	0.95	22.53	28.49	0.05	6.57	34.62	18.81
15	Male sterilization	5.6	2.26	4.14	2.32	0.92	2.52	11.32	3.49	30.09	20.64
16	IUD insertions	120.17	67.38	68.84	75.56	110.27	94.32	77.43	56.59	102.68	111.16

**As per PCTS, Directorate of Health and family Welfare, GoR, 2013-14

2.4 Behavior Analysis

Individual behaviours are embedded in social environment. Success of a behavior change intervention is greatly dependent on the extent to which efforts are made to understand the individual in the socio-ecological context and the barriers faced by her/him at each of the levels. Many desired behaviours are not followed by the community or only intermittently followed due to personal, familial, social or institutional barriers. The socio-ecological model (Figure 1.6) shows that an individual cannot be treated in isolation and any behavior change intervention will have to consider all the layers which surround the individual.

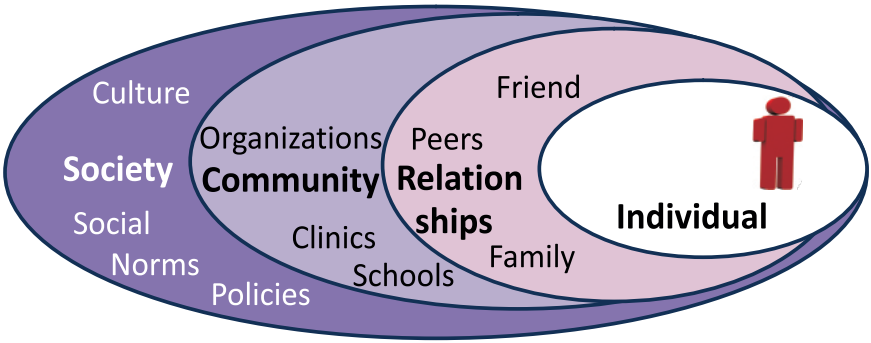


Figure 1.6: Socio-ecological Model

Table 1.7 shows Key barriers faced by people for the desired behaviors across the life stages. More detailed list of barriers has been provided in Annexure 6.2

Table 1.2: Identification of specific behavioral issues by life stages and barriers faced

Life Stages	Identified specific issues	Barriers Faced			
		Individual	Family	Social	Institutional
Reproductive and Maternal Health	• ANC not registered in first trimester • 4 ANC checkups not completed • Low consumption of IFA tablets	• Disclosure of pregnancy is a taboo • Do not realize importance of ANC • IFA associated with gastric trouble/constipation • Do not appreciate the dangers of anemia for pregnant woman	• Low awareness on dangers of anemia	• Delivery considered as a routine activity which do not need any specialized care	• Availability of kit (*Nichay*), • Confidentiality not guaranteed • Supply of IFA not regular • Instruments not in functional condition
	• Post delivery Stay at the facility for less than 48 hours	• Women is not the decision maker in most cases	• Low conviction on importance of postpartum care • No arrangement for attendants at the facility	• Conviction that if mother and child are safe at the time of delivery, there is nothing to worry	• Hospital staff is not cordial and well-behaved • There is no place for the attendant to stay in the hospital
	• Low coverage of PPIUCD	• Lack of spousal communication • Myths about IUCD-obstruction in sexual life, pain, heavy bleeding	• Relying on Amenorrhea period without much knowledge of confounders		• Only woman is addressed while the decision is to be taken by both partners • Unskilled staff
	• Spacing methods not preferred	• Importance of spacing not realized • Lack of spousal communication • Desire to complete family size • Spacing methods, especially those requiring medical staff intervention considered hassle	• Son preference • Importance of spacing not realized	• Pressure to complete family	• Need-based contraceptives not available • Supply of contraceptives not regular

Table 1.2: Identification of specific behavioral issues by life stages and barriers faced (Contd.)

Life Stages	Identified specific issues	Barriers Faced			
		Individual	Family	Social	Institutional
Neo-natal and child Health	• Initiation of breastfeeding delayed • Colostrums not given to child • Children not exclusively breastfed • Home-based post-natal and neo-natal care including cord care neglected • Baby is not kept warm	• Mothers are not the decision makers for early child care like initiation of bf, colostrums and keeping baby warm • Exclusive breast feeding not practiced – belief that breast milk cannot support the child's nutritional needs Importance of cord care and keeping baby warm via skin to skin contact not completely known	• Mother-in-law doesn't approve of early initiation and colostrums • Belief that the thick colostrums would stuck in baby's mouth • Illness is often ascribed to supernatural powers and therefore seeking care is often delayed	• Cultural /traditional practices of giving bath to baby, not clothing baby, feeding prelacteals, not allowing weighing and colostrums	• Benefits of early initiation of Bf and colostrums not informed • Feeding of prelacteals is common and also allowed by the staff • Advice on when to give first bath to baby and within 7 days often not given
	• Poor Hygiene practices	• Importance of Hand washing before feeding and after cleaning baby not realized	• Babies excreta not considered harmful	• Link between diarrheal infections, contamination of water and foods given to babies not recognized	• Week Convergence between WATSAN and Health department
	• Complementary and Supplementary food not initiated timely	• Type and frequency of feeding baby not known	• Discipline wrt to feeding baby is missing, baby eats with everyone but complete diet is not ensured	• Misconceptions on requirement of child feeding	

Table 1.2: Identification of specific behavioral issues by life stages and barriers faced (Contd.)

Life Stages	Identified specific issues	Barriers Faced			
		Individual	Family	Social	Institutional
	• Immunization is not compete	• Importance of immunization for the child's health not considered as priority and one's duty • Do not want to hamper ones daily's routine and wait to be immunized	• Immunization considered as health providers' duty • Want to avoid fever and discomfort to the child	• Prevalence of some myths in some communities	• Immunization services not provided at all the times • due list not prepared to identify the children who are to be immunized
	• Do not allow weighing of the baby	• Weight as an indicator of health not realized	• Weighing is considered as resulting in casting of shadow/evil eye	• Culturally weighing is not recommended	• Advice and need-based counseling after weighing is not given
	• Delay in managing diarrhea cases • Delayed health seeking in case of ARI/ Pneumonia • ORS not used in the desired manner	• Close association between hygiene and diarrhea not understood • Importance of continuity of feeding – breast milk and home based feeds during diarrhea not well understood	• Accessibility of health services poses problem • Availability of services at public health facility not ensured • RMPs are approached for ease of services	• Home-remedies are preferred	• Non-availability of referral services • Preparation of ORS, use of ORS packet not informed

Table 1.2: Identification of specific behavioral issues by life stages and barriers faced (Contd.)

Life Stages	Identified specific issues	Barriers Faced			
		Individual	Family	Social	Institutional
Adolescence/ Pre Pregnancy	• Anemia	• Low conviction on importance of taking WIFS	• Traditional way of cooking which result in loss of important nutrients • Lack of diversity and green leafy vegetables in diet		• Irregular supply at the designated place • Low conviction/involvement of the providers-teachers
	• Cloth used during menstruation	• Non availability of Sanitary napkins • Low conviction on benefits of napkins over cloth • Problem of disposal of napkins	• Tradition to use cloth		• Irregular Supply of sanitary napkins • Quality of napkins not good
	• ARSH services not used	• Embarrassment in discussing ARSH issues		• Stigma attached to seek services at ARSH	• ANM/AWW/ health Workers not interested (not skilled) in discussing RH issues with adolescents
	• Contraceptive methods not used just after marriage • First pregnancy after marriage not delayed	• Non-availability of desired methods	• Desire among in-laws to become grandparents	• Societal pressure to prove fertility	• Lack of basket approach • Weak counseling services

Steps of Behavior Change

Behaviour change goes through certain steps. The first step to behavior change is knowledge followed by approval, intention, action and advocacy. The above analysis shows that majority of the target audience do not face barriers related to knowledge. The knowledge might be incomplete but majority are aware of the desired behaviours. In view of the current situation which shows that people are already above the pre-knowledgeable stage, efforts need to be made to identify the specific audience and address the barriers faced us the adoption of behaviors change by using appropriate communication strategies.

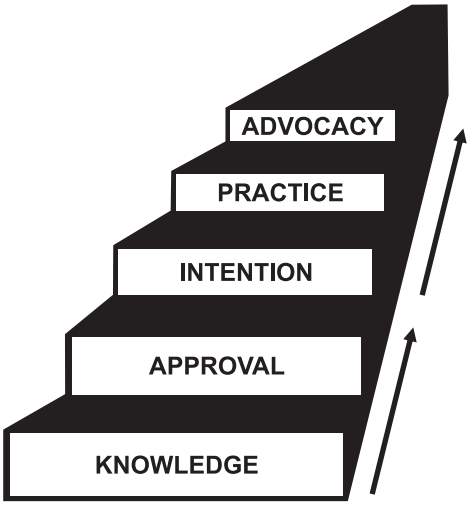


Figure 1.7: Steps of Behaviour Change

2.5 Key Audiences

In view of the socio-ecological and behavior change model, it is evident that selection of correct key audience will determine the success of social and behaviour change communication interventions. The audiences for the key behaviours under each of the life-stage as included in RMNCH+A have been identified. Table 1.3 presents primary, secondary and tertiary audience for SBCC interventions at the community level. It also includes the health staff for facility-based SBCC interventions.

Table 1.3: Key Audience for SBCC interventions by different life stages

Key Desirable Behaviours	Audience for Behavioural Interventions			
	Home/Community-based			Facility-based/Services Providers
	Primary	Secondary	Tertiary	
Reproductive and Maternal Stage				
Registration of Pregnancy during first trimester	Woman	Spouse and Mother-in-law	Community	ANMs and ASHAs
4 ANC checkups	Woman	Spouse and Mother-in-law	Community	ASHAs and AMSs
Institutional Delivery	Woman	Spouse and Mother-in-law	Community	ASHAs
PPIUCD	Woman and Spouse	Mother-in-law	Community	Health providers –ANMs, ASHAs
Stay at the facility for 48 hours	Woman and Spouse	Family	Community VHSC members	Health Providers
Neo natal and Child Stage				
Initiation of breastfeeding within one hour	Mother and Mother-in-law	Spouse	Community	Health Providers/ Nursing staff at the Facility
Colostrums intake	Mother and Mother-in-law	Community		Health Providers/ Nursing staff at the Facility
Exclusive Breastfeeding	Mother	Mother-in-law and Community		Health Providers/ Nursing staff at the Facility
Home-based post-natal and neo-natal care- cord care, baby bath, prevention of hypothermia	Mother	Mother-in-law and community		Health Providers/ Nursing staff at the Facility
Hygiene and safe water practices	Mother/care giver, Mother-in-law	Family	Community School VHSC members	ASHA, ANM
Immunization	Parents	Community	VHSC members	ANM, ASHA, AWW
Timely initiation of complementary food	Mothers/ Care givers	Community		
Growth Monitoring	Mothers/ Care givers	Community	VHSC Members	AWW, ASHA and ANM
Diarrhoea Management	Mothers/ Care givers	Community	VHSC Members	ASHA, AWW and ANM
ARI/Pneumonia Management	Mothers/ Care givers	Community	VHSC Members RMPs	ASHA, AWW and ANM
Adolescents/Pre Pregnancy Stage				
Weekly iron folic supplementation to Adolescents	Adolescents	Parents	Teachers	ANMs
Use of sanitary napkins	Adolescent	Mothers		ASHs, ANMs
Use of Contraceptives	Adolescent	Spouses/ Mother-in-law	Community	ANM, ASHA
Age at first conception	Newlywed couples	Mother-in-law	Community	ANM, ASHA

2.6 Communication Channels: Barriers and Gaps

The selection of communication channels will depend on the feasibility of their use in the rural areas, reach and exposure to the identified audiences.

1. Mass Media

Electronic: Electronic medium including television and radio are important choices of mass communication. However, the reach of both of these mediums is limited in Rajasthan. In rural areas of Rajasthan 54 percent of Households have electricity (NFHS-3) which limits the use of electronic media as a prime channel. NRS data (2005) reveals that 54.3 percent of Rajasthan's households do not own a television set and of the 45.7 percent that do; only 16.9 percent have access to cable and satellite channels. Frequency of radio listening is also low at 15 percent. While the proportion of viewers and listeners must have increased over the years, the scope of using this medium does not appear too promising as a prime mode of communication to the rural population.

Print: Print Media has been an important channel of communication interventions. However in view of the low literacy level - males at 79 percent and females at 48 percent (Census, 2011), media has limited reach. Also, given that female audiences are particularly important in the context of reproductive and maternal child health, Rajasthan's low female literacy suggests that print may not be the best communication media platform.

Digital: The new age of digital technology, particularly mobile phones have superseded all existing channels of communication with respect to exposure and reach. India has 55.48 crore mobile users. More than 29.8 crore, about 54 per cent, of these device owners are in rural areas as compared to

[3] http://mashable.com/2012/06/06/mobile-health-accountability-india/

[4] http://www.savethechildren.in/custom/recent-publication/NBCS%20TAG%20-%20Book%20of%20Proceedings.pdf
http://www.commcarehq.org/docs/rfa/div2/save_the_children_report.pdf

25.6 crore in cities and towns. (India Mobile Landscape (IML) Study, 2013). As per TRAI (Telecom Regulatory Authority of India), the overall teledensity was 72.9 percent as on February, 2013. In Rajasthan, 61 percent of the rural households were using mobile phones as per census 2011.

A number of small scale innovations of mobile-use have been introduced and piloted in different parts of the country. They range from ensuring health workers attendance in the field to assist her in providing counseling for ANC to pregnant woman . Similarly, UNICEF has used tablets with ASHAs to improve ANC. (Annexure 3) A few health programs like pulse polio have used mobiles to disseminate messages for immunization, but the opportunity has not been utilized to the possible extent by the public health system. The adaptability to the rapid advancements in technology needs to be increased so that this new medium could be optimally utilized.

2. Mid-media: Mid media campaigns focuses on communication through art/folk media Locally produced tools and aids always score over the ones which are developed for general use because of the familiarity and acceptability. Their reach to the intended audience is ensured as their use is planned with respect to specific target groups resulting into greater relevance and remembrance. Nukaad Nataks (Street Plays), specially developed CDs, songs based on traditional folk songs have been found to be particularly appealing to the masses both for seeking their involvement and motivating change. DVDs of Ammaji (Facts For Life) have been quite popular.

3. Inter Personal Communication: Effective IPC is required for counselling the target audience for desired behaviours. Two types of gaps in the way to effective counseling have been observed. One is related to lapses in the knowledge of Front-line workers (Bottleneck Analysis, UNICEF) and second is

regarding untrained service providers. Use of various communication tools and counselling aids is not known. Monitoring and supportive supervision is yet to be institutionalized and therefore health workers do not receive timely guidance and handholding support which adversely affect counselling process.

2.7 Social and Behaviour Change Communication: Challenges and Opportunities

Social and Behavior Change Communication faces certain challenges which affects the implementation and pace of interventions. There are, however, certain opportunities which could be used as enabling factors to introduce and sustain behavior change interventions. In the context of Rajasthan, Figure 1.8 presents specific challenges and opportunities to be considered for implementing SBCC interventions.

Breast Feeding Corners (Amrit Corners)

Recently the Government of Rajasthan has taken a decision to introduce a Breast Feeding Corner to be established at all delivery points near labour room in the state. All women after delivery are to be shifted to this corner (provision of two beds- depending on the delivery load) so as to ensure initiation of breastfeeding within one hour of delivery. One of the staff working in labour room- Staff nurse/Yashoda/ Medical officer/paramedic- is to be appointed as a nodal officer for early initiation of breast feeding. They would be responsible for early initiation of breast feeding and providing related information. Counselling of mothers, caretakers accompanying the mother to the facility will be undertaken by trained paramedical staff. The district IEC funds budgeted under the state RCH PIPs will be sanctioned for this innovation. (Source : DHS 2014)

Social and Behaviour Change Communication

Challenges

Related to Management

- SBCC is not a priority for administrators
- Weak capacity for planning and Implementing BCC programs
- Unaware and un-sensitized media
- Uncoordinated and unfocussed mass media campaigns

Related to Service Providers

- Gaps in knowledge and skills of frontline workers- ASHA, ANM, AWW leading to ineffective counselling during home visits
- Little or non-use of available counselling tools/ aids like flipcharts, flashcards, talking points etc
- Windows of opportunity for promotion of key behaviours at facility are not fully utilised- initiation of early and exclusive breastfeeding, counselling during MCHN sessions

Related to Communication Medium

- Low reach of mass media
- Over dependence on IEC materials which are information - driven
- mass media campaigns

Opportunities

Related to Community

- Majority of primary, secondary audiences is knowledgeable of the desired behaviours
- Barriers to behavious are known to a great extent

Related to Service Providers

- Availability of three existing resources - providing services at HH level – ASHAs, AWWs, ANM
- Successful innovations piloted by Development Partners and CSOs – UNICEF, NIPI, UNFPA, EARTH, Save the Children

Related to Management

- Pro-activeness of Health system to facilitate behavior change at the facility level -Amrit Kalash Corners

Related to Communication Medium

- Technology Use : e-health and m-health

Figure 1.8: Challenges and Opportunities for SBCC

3. Strategic Communication Framework

The interventions designed under RMNCH+A are an illustration of emphasis on establishing the 'continuum of care', which includes integrated service delivery at various life stages. The continuum of care for maternal, newborn, and child health refers to continuity of individual care and is critical throughout the lifecycle (adolescence, pregnancy, childbirth, the postnatal period, and childhood) and also between places of care giving (including households and communities, outpatient and outreach services, and clinical-care settings). Health programs are vertically managed and therefore different departments are found to be responsible for providing the services to the beneficiaries across the life stages.

The Social and Behavior Change Communication Strategy, however, adopts an integrated approach which is two pronged: i) behavior change of service providers at institutions (facility, outreach and community) ii) behavior change of families, communities at the individual and societal levels

Based on the situation analysis, a SBCC Strategic Framework for implementing SBCC for RMNCH+A in Rajasthan has been suggested in Figure 1.9.

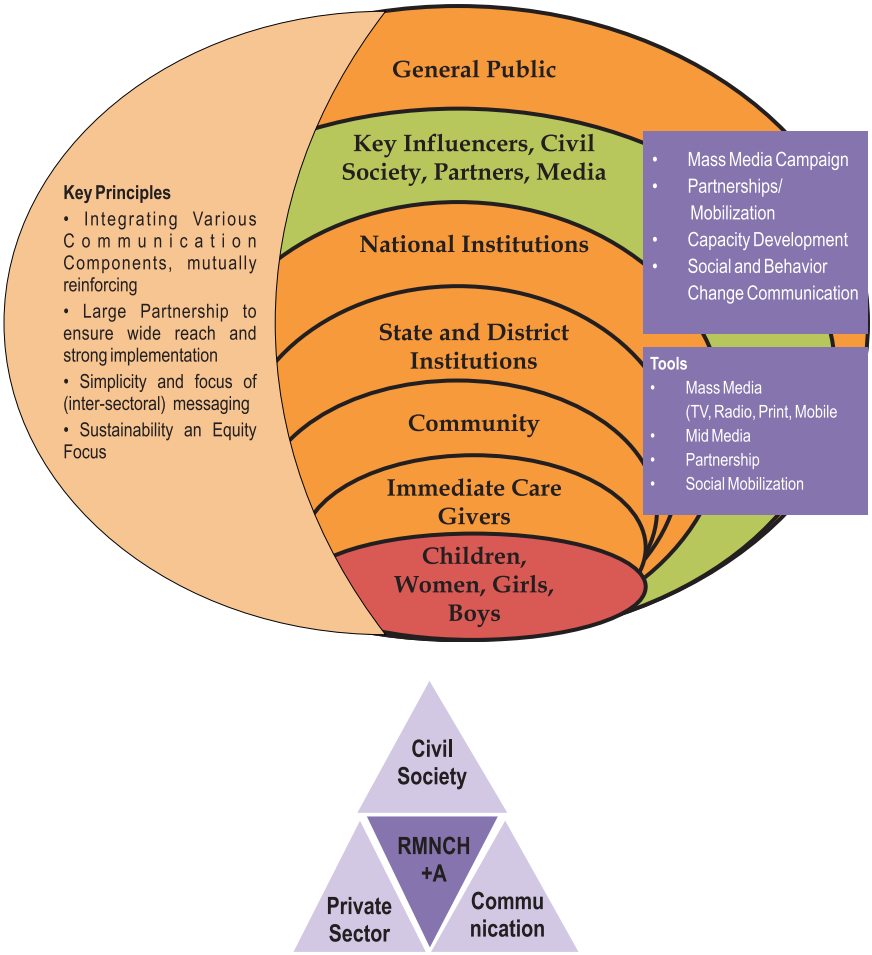


Figure 1.9: SBCC Framework for RMNCH+A

3.1 Key Approaches for SBCC

The three overarching approaches- **Advocacy, Social mobilization** and **Interpersonal Communication (IPC)** have been selected to best cater to the gaps identified through barrier analysis.

Advocacy includes highlighting the issue on the administrative/programme management agenda via meetings/discussions with various categories of government and community leadership, service providers, administrators, partnership meetings, network deliberations and media in the form of news coverage, talk shows, soap operas, celebrity spokespersons, discussion programmes, etc.

Social mobilization enhances population awareness and interest. It includes community mobilization via information, education, motivation for action through use of participatory methods such as group meetings, partnership sessions, school activities, traditional media, music, song and dance, road shows, community drama, leaflets, posters, pamphlets, videos, home visits.

Interpersonal Communication involves interaction with beneficiaries at household and community level and service points with appropriate BCC and mid-media tools like informational literature like flip books, guides, talking points which allows for initiation of discussion and careful listening to people's concerns and addressing them.

In addition to these primary approaches, other mediums will be used for supporting the interventions. They are:

Mass Media and Mid-media: The importance of mass media is in its power to reach and make aware almost all sections of society who have access to this tool and keep the issue alive in their memory. The tools of mid media are assumed to have high impact value, especially if the reach of television and other electronic modes of communication is limited. The tools

of **mid media** uses the entertainment–education approach which states that communication can bring about a change in attitudes and perceptions if it caters to the head and the heart. Thus, more than informing or creating awareness, the messages delivered through events or stories trigger an emotional response in the audience, resulting into realization, contemplation and moving towards change. This is accentuated with the use of local folk tunes, themes, songs and background effects.

Public Information Campaigns are primarily used to inform people about different government programs and schemes. Effort would be made to use this channel of dissemination for promoting behaviours in thematic fashion.

In order to utilize the window of opportunity at the facility level, **Standard Operating Procedures** would be prepared for health providers for each of the stages so that opportunities for counseling on healthy behaviours are not missed.

Partnerships: Involvement of all stakeholders in SBCC interventions increases the likelihood of its acceptance and success. Partnerships with private partners for clinical and infrastructural support like accreditation of private institutions for health services and with development partners for technical support have been more instrumental in achieving success for the public health programs. Public Health System could forge partnerships at each level of planning, implementation and monitoring of SBCC interventions. Advocacy would be done to network and partner with various CBOs and NGOs working in the area to enhance service delivery. Partnerships at the implementation level, in particular would be targeted for CBOs. NGOs, Faith-based organizations, youth clubs like NYKS, Corporate Offices under CSR and SHGs.

Table 1.4: SBCC Approaches by Objectives

Approach	Primary Objective	Secondary Objective	Barriers
Mass Media-TV and Radio ads and PSA-Theme –based	Awareness generation	Reminder Cues	Lack of Knowledge/ Unable to remember
Print- Flip books/Flash cards/games, Quizzes, SOPs	Understanding and Approval	Visual positioning	Lack of Knowledge/ Unable to remember
Electronic-Mobile and Videos	Visual stimulation	Reminder Cues	Lack of Approval
Mid Media	Cater to head and heart	Benefits	Lack of Approval and Intention
IPC	Addressing the specific barriers	Benefits	Lack of Approval, Intention and Action
Social Mobilization	Enabling Environment	Participation	Lack of ownership
Advocacy	Seek participation and ownership	Create Visibility	Lack of Involvement

3.2 Message Development

Behaviors fall into several categories and can be both preventive and those requiring treatment. An analysis of recommended behaviors to be promoted in the continuum of care (-12 weeks to +12 months) for the care seekers and caregivers of health services under RMNCH+A along the life cycle approach indicates that the practice of these set of behaviours is influenced and mediated by various participants and factors in the external environment. In the continuum of care approach, widow of opportunity for integrated counseling lies at points of contact with family by facility level worker at homes, facility or outreach. Table 1.5 presented below shows the specific communication materials and messages for each of the beneficiaries.

Table 1.5: Message Content, Communication Strategy and Communication Tool by Desired behaviors

Desired Behaviours	Message Content	Strategy	Communication Tool
Reproductive and Maternal Health			
Complete ANC with registration in first trimester	Importance of early registration for the health of mother and baby Importance of checkups, TT and IFA Need-based counselling on the results of the check-up Intimation of follow-up date Importance of iron Balanced Diet Role of IFA How /When to take Normal implications- stool black in colour	IPC Social Mobilization Advocacy	Counselling Meetings Thematic issues in VHSNC and MCHN day Videos on the growth of baby and importance of monitoring via weight, BP and other tests done for ANC Flip Book /Videos on danger signs, problems due to iron deficiency
PPIUCD	No Pain No obstruction in sexual life Hassle free Does not go up, cannot go Could be removed at any point Harmless/no side effects	IPC	Counselling Video on how IUCD works and to dispel the myths
Post- Delivery stay at the facility	Importance of facility-based care for the health of mother and child	IPC Advocacy	Counselling Videos on post-partum danger signs

Use of Spacing methods	Spacing important for health of mother and child Need-based options are available Hassle free Could be removed/discontinues at anytime	IPC Mid-Media	Counselling Street Plays
Neo natal and Child Health			
Breastfeeding practices-early initiation, colostrums intake and exclusive Breastfeeding	Benefit of early initiation, colostrums and EBf Frequency of breastfeeding Child doesn't need anything not even water , juice or pre lacteals Making the child even lick other food items defeats the purpose Protects child from diseases In case child in on medication or mother could not feed, details on desired action to be given	IPC	Counselling and use of Video clips for community level Ensuring of compliance by attending nursing staff via a checklist based on SOPs
Keeping baby warm -Skin to Skin contact	Importance of keeping baby warm irrespective of the season How to keep baby warm When to give first and subsequent baths	IPC	Counselling Flash cards Flip book
Weighing of the child	Advice and need-based counselling after weighing the child	IPC Advocacy	Counselling Videos Growth-charts
Immunization	Preventive role of vaccines When and where Side effects What needs to be taken in case of fever Time of next visit	IPC Advocacy	Counselling Video Mobile message Sessions in School

Diarrhoea Management	Link between cleanliness and diseases-diarrhoea Continue Breastfeeding Use of ORS in case of Diarrhoea	IPC Mass Media	Counselling Video
ARI Management	Importance of promptness in seeking care Symptoms and how to differentiate from common cold Place of seeking services	IPC Mass Media	Counselling Video
Adolescent Health			
For reducing Anaemia	Benefit of taking WIFS regularly Implication for pregnancy and child birth Importance of regularity How /when to have Place of availing the services	IPC by ANM or ASHA Teacher	Flip Chart
	What makes the diet balanced-region specific		
	How to cook to retain the nutrients		
For Menstrual Hygiene	Association of hygiene, RTI and use of sanitary napkins How to dispose of used sanitary napkins Where to get napkins from How to use cloth hygienically in case of non-availability of sanitary napkins	IPC by ASHA and ANM	Stories CDs-Messages interspersed with popular songs Flash Cards Small group meetings
ARSH	Difference between RTI and STI Causes of RTI Whom and where to contact in case of any complain for RTI /STI Timing of ARSH clinic	IPC by ASHA and ANM	Flash Cards Flip Book Games Short movies Z cards Mobile messages
Delaying of first pregnancy	Ease of use Basket of methods available Good for health of mother and baby	IPC by ASHA/AWW By Teacher/ANM Mid Media	Counselling using FP Guide Book Decision making Wheel Sessions in School

4. Implementation of SBCC Strategy

4.1 Existing Implementing Structure

A critical component for implementation of planned BCC interventions necessitates the availability of an administrative structure including adequate human resources with the capacityof implementing behavior change programs.

Established structure at State: Rajasthan prides at the fact that it was the first one to have established State IEC bureau in Health department in 1990. The Bureau was a vibrant body and it functioned with the following role and responsibilities:

- Planning, executing, monitoring and evaluating IEC Programmes
- Taking up extension education activities
- Producing communication material
- Carrying out training and research activities related to IEC

The allocated role and responsibilities have remained same but the bureau could not sustain its efforts and currently suffers from many limitations. A simplistic definition of BCC exists at all levels. It assumes that "people are ignorant and therefore need information". This myopic view of the behavior change process does not take into account the determinants (barriers and enabling factors) of behavior change. It is necessary to focus on the causes of the barriers and learn from the enabling factors to promote strategies of behavior change. Only select channels of communications are being used. Mass media use is more preferred in place of interpersonal communication and community mobilization. The most important concern is that of staff adequacy and staff competency.

Human Resource: Findings of a study undertaken by MSG Consultants on behalf of MoHFW and UNICEF (2007) to assess the IEC division and IEC Bureau of seven states has

great relevance to understand the gaps in systems and capacity of the state to effectively implement BCC strategies and programmes in the state. The gaps identified for Rajasthan are:

- Human resource under NRHM is underutilized for BCC supervision at the state, district, block and village levels
- Lack of coordination among different departments and implementing agency of the BCC activities.
- Weak capacity for planning and Implementing BCC programs
- Weak community based BCC inputs
- Uncoordinated and unfocussed mass media campaigns
- Lack of adequate BCC capacity in the state to implement BCC programs at scale

The existing situation of the staff at the state and district level has been presented in annexure III. Out of 443 sanctioned positions, only 47 positions are filled, many of the positions have not been filled from years. Hence, the existing structure of State IEC bureau needs to be strengthened to function effectively.

4.2 Roll out Mechanism

The roll out of the SBCC Communication Strategy in 10 HPDs to begin with would need to give adequate attention to the planning, implementing and monitoring structures corresponding to the state/ district/ block and village level. This will call for optimum utilization of available resources of manpower and support systems.

- **Planning and Implementing Structure:** At the state level, the following recommendations are made to strengthen the implementation structure and facilitate proposed communication interventions:
- Constitution of SBCC coordination committee under the

chairpersonship of Principal Secretary, Medical and Health by involving all the Directors and PDs with Director, IEC as Member Secretary.

- Establishment of Communication Resource Hub at state level: A number of communication interventions are implemented by development partners, NGOs and CBOs at different levels but they remain limited in their reach and impact due to isolated approach. Many a times their application is limited to the organization which had developed them. Communication resource hub will act like a repository which will ensure that all communications resource materials are there. This will ensure greater learning from each other's efforts, replication and innovation.
- SIHFW to be awarded the role of mentor for capacity development for implementation of SBCC interventions
- Assigning of responsibilities to CSOs and Development Partners
- Establishment and strengthening of monitoring system for implementation of SBCC activities in the state linked to state HMIS systems.

District Level: ASHA facilitators at the district level have been re-designated as District IEC Coordinator by State IEC Bureau. They will be responsible for ensuring the implementation of the SBCC activities in the district. In addition, SIHFW can develop its monitoring team or outsource the monitoring work to some agency (Annexure 6.4)

Block Level: Block ASHA Facilitators would oversee the implementation of SBCC intervention at the block level.

Village level: AAAs will be responsible for implementation of SBCC intervention at the village level.

The three Front Line workers are the service providers of the

two flagship programmes NRHM and ICDS – ASHA, ANM and AWW – address the needs of the same participant groups of mothers and children in the -12 and + 12 years age group in the life cycle approach to child survival and development. It is understandable that their effectiveness can improve if they work in a coordinated manner through joint planning, synchronized visits and monitoring. The group for services provided by Anganwadi Worker (**AWW**) through the Anganwadi Centre comprises of adolescent girls (girls aged 10-19 years), women in reproductive age group (females aged 15-44 years) (including pregnant and lactating mothers) and children less than six years. The main issue before the Health Worker (**ANM**) is survival and growth / development of the mother and the child (in addition to other health issues like TB, malaria, AIDS, etc.). The third category of frontline functionaries, the **ASHA-Sahayogini**, also has the major responsibility of social mobilization for survival and development of the mother and the child.

Thus, these workers could very well work for implementation of SBCC interventions at the community level and at the facility level where they function. The activities of these workers would be monitored by involving community members like VHSNC members. The health facility PHC in-charge would also be involved for handholding of the frontline workers.

ASHAs using Tablet to aid counseling to mothers (UNICEF)

E- ASHA initiative was launched by UNICEF in the month of April 2013 with 28 ASHA Sahyoginis of PHC Jasole, Balotra Block at Barmer district one of the 10 HPDs in state under CTA and RMNCH+A. E ASHA is a joint initiative of UNICEF, IIT Jodhpur and DHFW. The objective was to develop an android based application which can be used to provide integrated package of essential MNCH services (counselling, identification of danger signs, data management, real time monitoring) using technology options. A technology platform was developed on tablet PCs which is simple enough to be used by a village ASHA worker whose educational qualifications are generally up to class 8th. The application also helps in improving counselling skills by including audio video and customized feedback and reminder mechanisms. The expected results of use of this application was to generate real time monitoring data, improved counselling with backup server logs and feedback loops.

The software underwent many revisions and was customised by IIT Jodhpur over a series of meetings with the field functionaries and now it is ready for replication in other areas. ASHAs shared that the use of tab has increased their knowledge as well as generates interest of not only beneficiaries but mother in laws especially because of the videos.

mHealth Improving Maternal and Child Health Service Delivery in Rural India (Save The Children)

Save the Children used a mobile phone-based job aid to pilot the use of technology in improving health of mothers and newborns by ASHAs in rural India. The mobile phone

application forms were submitted by ASHAs through GPRS connectivity on the centralized cloud server which were seen, monitored and analyzed by the project staff to monitor the work progress of ASHAs. Application depicted the trends of form submission, progress on different indicators like institutional delivery, immunization status, malnourishment prevalence etc for sharing with line departments.

ASHAs could confidently use the mobile application to register the beneficiaries (pregnant women and children below 2 years of age), tracking and recording the behaviors and use of services.

Experiences gained from the pilot project have established the efficacy of mobiles as a job aid for ASHAs and have demonstrated a high potential for scale up.

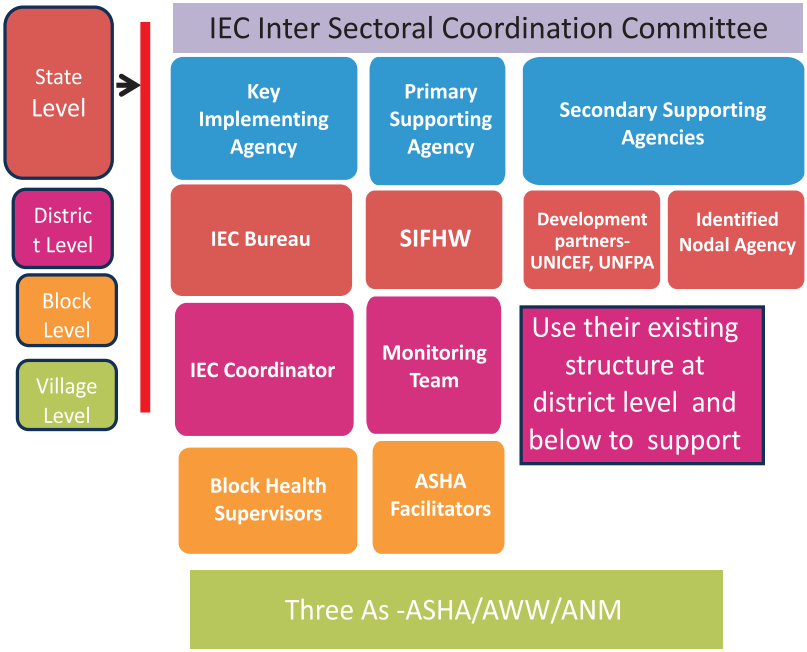


Figure 1.10: Implementation structure by administrative levels

In addition to the above, the following points are critical for implementing SBCC interventions

- Advocacy for devoting two-days for MCHN Day; VHSNC meeting for manning and implementing SBCC activities
- Prioritizing the essential institutional support required for implementation of SBCC via coordination and convergence with other departments
- Identification of the areas where ANM , AWW and Ashas are not present and developing a specific plan for implementation of SBCC interventions in such areas
- Development of capacity development plan and identification of resource agencies for its implementation.

4.3 Capacity Building

The proposed implementation structure has taken care that additional staff is not required at each of the levels and neither are the existing staff unduly burdened due to SBCC interventions. The work expected from the front line workers under SBCC interventions is well within the purview of their responsibility. The SBCC interventions would ensure that responsibility to each of the staff is discharged in a more professional and out/come oriented way. Studies conducted in the past have pointed out to skill and attitudinal deficiencies for this level.

A rapid assessment of MCH Services in 5 High focus districts in Rajasthan conducted by UNICEF (2010-2011) revealed that there are gaps in knowledge, skills, capacity and coordination in functioning of Anganwadi Worker, ANM and ASHA Sahyogini. Key knowledge gaps were found in -

- Danger signs related to pregnancy and in postpartum period
- Timely initiation of complementary feeding at 6 months of age

- Proper positioning of newborn for breastfeeding
- Essential newborn care
- Elements of focused ANC

Skill gaps were also identified for all the three workers and it was found that they lacked skills in

- Preparing due List
- Weighing child
- Plotting weight of child on Growth Chart / MCP Card
- Interpreting plotted weight of child on growth chart
- Preparing ORS solution
- Measurement of Blood Pressure
- Use of AD Syringe and needles
- Providing essential newborn care
- For focused ANC Counselling
- For hand washing Counselling

The proposed SBCC interventions would be implemented by these three 3AAAs and they need to be equipped not only with knowledge and skills but there is also need to foster positive attitude in them by providing due recognition and appreciation of their work.

Lack of coordination between ANM, ASHA and AWW has also emerged as key gap in delivering the quality health services in previous studies and hence capacity building initiatives would consider this aspect too.

Capacity building training would focus on filling the knowledge and skill gaps and also in counselling and negotiation skills for working at the community level. The focus would be on:

- Enabling the workers to use all the prepared communications aids and resources with the community

and to appreciate their value in initiating and facilitating the interaction or counselling and feel confident in using them.

- Sector meetings would be used for refresher sessions. Medical officers of the health facilities would also be oriented on the skill up-gradation of ANM and ASHAs and they would also guide them in their monthly meetings.
- To motivate the workers, the ones who excel would be recognized at local or block platform and would be awarded certificate by community leaders.

The monitoring team would provide mentoring support to these workers during field visits/home visits/ MCHN day sessions.

The block and district level officials would be trained in networking skills so that they could work with policy, management and media to advocate the issues which would benefit the implementation of SBCC strategy.

Figure 1.11 shows conceptually the skill expected at each of the levels with respect to their responsibilities

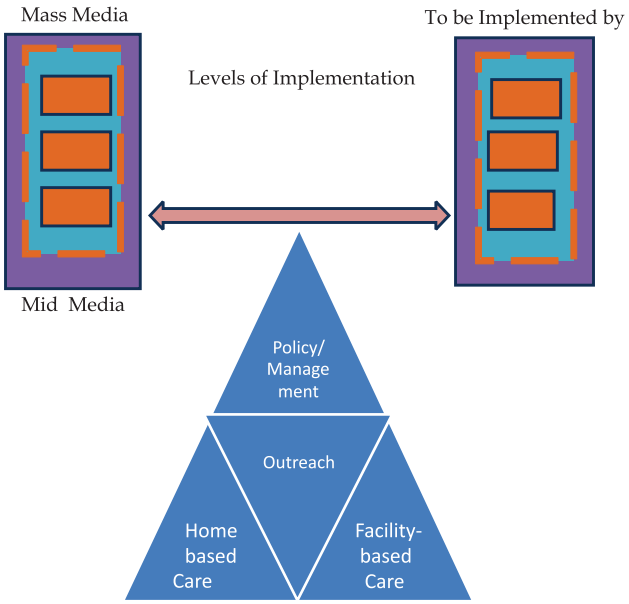


Figure 1.11: Conceptual Diagram for capacity building

Above the level of 3As, the IEC coordinators, ASHA Facilitators at the block level need to be trained in networking so that they could advocate issues with media, management and development partners so that implementation assumes a synergy. This could be done through joint training for the implementers and supervisors for providing supportive supervision for making corrective actions if required by the district and block level officials.

4.4 Time Line : 2014-15

For rolling out of SBCC interventions, the implementation could be viewed in four phases. The first phase is of planning and developing of material and training the functionaries. The second phase is of implementing the interventions and monitoring its progress and third phase is of rapid evaluation to assess the effectiveness of the interventions. The fourth phase would be devoted to re-planning the activities in the light of findings.

The steps and time line for each of the phases is presented underneath:

SN.	Actions/Activities	Year I				Year II			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
I	Preparatory Phase								
1.	Orientation to departments on the implementation of SBCC								
2.	Scanning of existing print ,electronic , m -health IEC material to assess suitability from available resources, GOI IEC website for RMNCH+A, Development partners								
3.	Prioritizing the barriers to be addressed								
4.	Preparing multiple copies of the material found suitable								
5.	New BCC tools –scripts , games , comic strips, talking aids, Flash Ca rds, Mobile messages, videos, radio and TV spots to be developed and pre -tested and finalized with specific reference of messages to barriers and in conformity some Behaviour change model /theory								
6.	Assessment of adequacy of supervisory and implementing staff and its competency and identifying areas of training								
7.	Advocacy for equipping IEC Bureau, VHSNC meeting to be conducted prior to MCHN Day								
8.	Advocacy for institutional support via coordination and convergence								
9.	Advocacy for conducting MCHN Day and VHSC meetings back to back								
10.	Preparation of guidelines for conduct of MCHN Day, VHSC meetings, Theme -based PSAs, village contact drive and media sensitization								
11.	Preparation/Revision of training modules on counselling, negotiation, networking, FAQs								
12.	Identification of Master trainers to provide training to field workers or identification of agency for outsourcing								
13.	Conducting training for Master Trainers								
14.	Onsite training of functionaries by Master trainers in the HPDs								
15.	Preparing the implementation plan for SBCC activities								
16.	Distribution of all IEC/BCC materials at the required places								
17.	Identification of areas which are Hard to Reach and feasibility for using mobile vans for SBCC								
II	Implementing and Monitoring Phase								
18.	All activities as per implementation plan								
19.	Airing of TV and radio spots								
20.	Print material to be used at the designated places								
21.	Hand holding via Monitoring								
22.	Documentation/ reporting on monitoring visits								
23.	Advocacy for using of mobile vans in remote /hard to reach areas of HBDs								
III	Evaluation Phase								
24.	Rapid Assessment to assess the effectiveness								

5. Monitoring of SBCC Strategy

The Department of Health and Family Welfare, GoR has established an efficient HMIS to track the progress of crucial state, district, block and even village level indicators. The information is collected from Sub-Center level to district hospital on monthly basis. The information is collected as per SDRs (Form 6-9) at each of the levels. While the information is complete to understand the status of services at any of the desired levels, it does not include information on any of SBCC indicators. Advocacy would be required at the state level to include some key communication indicators. Below are given the key tools which could be used at the state level to monitor the status of services.

5.1 Key tools of Monitoring

Web-Based

- PCTS: Pregnancy Child Tracking System: Launched in 2009, it is a computer--based HMIS for reliable and cost-effective monitoring to facilitate better decision-making, planning, implementation and monitoring of effective service delivery system. It was introduced with the objective to do case-specific monitoring of every pregnant women and child to reduce maternal and infant mortality. It could be used for listing out the drop outs and left-outs and to track ANC, Delivery and Immunization.
- Web-based tracking system for ICDS: ICDS would be introducing web-paced HMIS to track status of the services delivered by Anganwadi Center. All the information would be on computer and it would be primarily used to track regular weighing of the children registered at AWC.

Office-based

Monthly Reports and Formats are filled by each of service

delivery systems. But they do not include any process indicators which could monitor SBCC interventions.

Field-Based

Monitoring via field visit is an important tool to track the progress of the work but this could not be streamlined due to multiple reasons. The monitoring visits are however, integral component of the current SBCC strategy. The monitoring from the state would be done by the existing staff. ASHA Coordinators from the district and ASHA Facilitators from the Block would be monitoring the field level visits on regular basis. The purpose of the visit would be as under:

Record Validation: The three workers (ANMs, ASHAs, AWWs) provide services at the house-hold level. IPC has been proposed as an important approach for implementation of SBCC. The monitoring team to field would validate the information from a few selected households based on the information recorded in the registers and diaries.

Observation using checklist: Appropriate and Up-dated Display of information on MCHN Day, VHSNC meetings and AWC would be checked with the registers.

Spot Check and Back Check using checklist: A checklist would be used to observe the counselling process by the workers. A few households/beneficiaries already counseled prior to the visit would be randomly selected and visited to collect information on the correctness of information, use of counselling aids and its effectiveness.

Identification of areas which need correction: The monitors will provide written feedback to the workers on the areas which need correction based on the checklist filled by him/her. A copy of the same would be sent to all corresponding levels of block, district and state levels so that the same could be followed up in the subsequent visit in synchronized manner.

Documentation of field visit: All field visits would be documented and submitted. Emphasis would be on documenting best practices and regional innovations so that they could be replicated at other places.

The SBCC strategy emphasizes on prioritizing so that maximum effect and impact could be observed on the desired behaviours. Based on the same premise, monitoring indicators have been incorporated for desired behaviours for each of the life stages:

5.2 Input Indicators

- Constitution of the coordination committee
- No of training sessions conducted for capacity building
- Type of communication material developed and pre-tested
- No of troops for street play trained
- Channel and Frequency of TV spots
- Channel and Frequency of radio promotion
- Development of tools for supportive supervision of service providers and recommendation for corrective action
- Training for monitoring and evaluation capacity development for block and district officials

5.3 Process and Output Indicators

For process and outputs indicators, below are presented supply side and demand side interventions for priority behaviors for which SBCC interventions would be implemented.

Supply side and demand side interventions

Priority behaviours	Supply-side	Demand-side Interventions
Pre Pregnancy –Adolescence		
• Safe sexual practices • Compliance with menstrual and genital hygiene management • Opt for safe abortion services where relevant	• Adolescent friendly health services/clinic, counselling available to all adolescent, married, unmarried and newly wed couples, counselling by frontline workers at community/Household level • Ensure education and counselling on menstrual and genital hygiene and care provided at facility and community level service providers • Availability of hygiene absorbing material with the frontline workers • Ensuring a safe disposal mechanism available at the village level	• IPC/ Counselling for adolescent girls and boys (in school and out of school) and key influencers at various community and facility platforms(VHNDs, VHSNCs, AWW centres, SABLA platforms, Schools, ARSH clinics and Sub centres etc.) • Formation of adolescent peer groups to maximize reach among adolescents as well as create positive norms and promote health seeking behaviour among peers. • Social/community mobilization to create an enabling environment for open and free dialogue to address social norms and other underlying factors related to delaying marriage, menstrual hygiene practices, sanitation and safe sexual practices. • Creating an enabling environment for inter-gender and inter – generational dialogue through community dialogue to address social norms • Reorientation and training of frontline workers on counselling for high impact/priority behaviours • Advocacy with district level officials to address system related barriers

Priority behaviours	Supply-side	Demand-side Interventions
Pregnancy		
• Complete ANCs (Early registration, 4 ANCs,+100 IFAs + 2TTs) • Birth preparedness and complication readiness(BPCR)	• ANMs /ASHAs conducting relevant examinations and counselling for complete ANCs (at least 4 ANCs) • ANMs, ASHAs and AWWs provide counselling on birth preparedness, complication readiness and early detection of danger signs and provide timely referrals where necessary as part of ANC counselling and care	• Media mix (choice of mid media and mass media) to promote compliance to complete ANC and rights based demand of ANC services. • Mix media and IPC to increase knowledge on health service entitlements and health seeking behaviours by ASHAs, AWW, SHGs, and through VHNDs • Use of positive deviants, especially women/mothers-in law to talk to other families in village during group/SHG meetings • Use of text, mobile, voice messages to • husbands through phones, community radio as relevant • Reorientation and training of frontline workers on counselling for key practices such as birth preparedness and related behaviours • Advocacy with district level officials to address system related barriers.
Post Natal, Maternal and new-born care		
• Deliver at a health facility • Stay for 48 hours post delivery • Three PNC visits/checks in the first week • Early initiation of breast feeding (including colostrum feeding) within	Active management of third stage of labour (AMTSL) Referral for treatment of complications (EmONC availability) Facilities equipped to	• Media mix (choice of mid media and mass media) to promote and encourage compliance for institutional delivery/ SBA. Includes promotion of new born care, PNC

Priority behaviours	Supply-side	Demand-side Interventions
one hour • Exclusive breast feeding and no pre-lacteals are including water or honey etc. • Thermal care (KMC) of new born, avoiding bath in first three days • Cord care • Intent to adopt family planning/spacing • Accept Immunization at birth • Baby weighing to identify LBW • Knowing LAM (lactation amenorrhea method-LAM)	allow stay/care of mother and new-born for at least 48 hours after birth ASHA adherence to 6 postpartumvisits up to 21 days Counselling and compliance of mother by SBA, ASHA, facility on breastfeeding including colostrum feeding Care of mother and newborn on day one. Post-partum counselling on contraceptives and community based doorstep distribution of contraceptives Immunisation counselling and services SNCU facilities for LBWs and preterm babies Provide information on LAM, SAM Ensure power supply at health facility Make available rights-based information for parents on services and schemes	care for mother and child, family planning, spacing and rights based demand for services. • IPC/counselling during ANC, byASHAs, AWW, SHGs, and throughVHNDs to women and family members on the importance and timing of PNC check-ups and related practices • Use of positive deviants, especially women/mothers-in law to talk to other families in village during group/SHG meetings • Use of text, mobile, voice messages to husbands, women, through phones, community radio as relevant • Reorientation and training of frontlineworkers on post-partum contraception, LAM, SAM, birth spacing methods and other key practices and home based care and prompt referral • Advocacy with district authorities to ensure PHC/sub centres provides women/family members with information on benefits of delayed newborn bathing, cord care, immunization, and relevant government schemes etc.

Priority behaviours	Supply-side	Demand-side Interventions
Child Health		
• Exclusive BF for six months • Appropriate IYCF practices (recommended feed for 6-11 months and up to two years , plus continued BF till 2 years) (Accepting De-worming twice a year) • Complete immunization • Fully Immunized Children(FIC) (including measles) • Early detection of danger signs- diarrhoea and pneumonia • Seek timely and appropriate health care for Diarrhoea and pneumonia • Sick child feeding and continuing BF • Enrol for pre school education	• Continued counselling on use of contraceptives(*information on return of fertility within 45 days,*) • Anganwadi to ensure ECE/Pre-School Education and nutrition Counselling and services on deworming by practitioners, PHC and CHCs • Ensure complete immunization through platforms such as VHNDs, or at PHCs, CHCs • Disseminate information and provide services for early detection and treatment of diarrhoea, pneumonia and other childhood illnesses • Ensure practitioner's advice and counselling on continued feeding of sick child • Ensure early and primary education for all children	• Media mix (choice of mid media and mass media) to promote and encourage compliance to exclusive breast feeding, IYCF practices, complete immunization, detection and management of danger signs and preschool education. • IPC/counselling during ANC, by ASHAs, AWW, SHGs, and through VHNDs to women and family members on the importance of compliance with infant and child care practices • Use of positive deviants, especially women/mothers-in law to talk to other families in village during group/SHG meetings Use of text, mobile, voice messages to husbands, women, through phones, community radio as relevant on key practices • Reorientation and training of frontline workers on post-partum contraception, LAM, birth spacing methods and other key practices • Advocacy with district authorities to ensure PHC staff provide women/family members with information on key entitlements, schemes and practices related to

Priority behaviours	Supply-side	Demand-side Interventions
		infant and child care and growth • Conduct needs assessments as relevant, develop communication, counselling tools for use by frontline workers, self-help groups

5.4 Impact Indicators

- Decrease in morbidity and mortality contributing to achievement of MDG 4 and MDG 5

5 x 5 Matrix for High Impact RMNCH+A Interventions

To be Implemented with High Coverage and High Quality

Reproductive Health

- Focus on spacing methods, particularly PPIUCD at high case load facilities
- Focus on interval IUCD at all facilities including subcentres on fixed days
- Home delivery of contraceptives (HDC) and Ensuring Spacing at birth (ESB) through ASHAs
- Ensuring access to Pregnancy Testing Kits (PTK-"Nischay Kits") and strengthening

  Comprehensive abortion care services
- Maintaining quality sterlization services

Maternal Health

- Use MCTS to ensure early registration of pregnancy and full ANC
- Detect high risk pregnancies and line list including severely anemic mothers and ensure appropriate management
- Equip Delivery points with highly trained HR and ensure equitable access to EmOC services through FRUs; Add MCH wings as per need
- Review maternal, infant and child deaths for corrective actions
- Identify villages with high numbers of home deliveries and distribute Misoprostol to select women in 8th month of pregnancy for consumption during 3rd stage of labour; incentivize ANMs for home deliveries

Newborn Health

- Early Initiation and exclusive breastfeeding
- Home based newborn care through ASHA
- Essential Newborn Care and resuscitation service at all delivery points
- Special Newborn Care Units with highly trained human resource and other Infrastructure
- Community level use of Gentamycin by ANM

Child Health

- Complementary feeding, IFA supplementation and focus on nutrition
- Diarrhoea management at community level using ORS and Zinc
- Management of pneumonia
- Full immunization coverage
- Rashtriya Bal Swasthya Karyakram (RBSK): screening of children for 4Ds' (birth defects, development delays, deficiencies and disease) and its management

Adolescent Health

- Address teenage pregnancy and increase contraceptive prevalence in adolescents
- Introduce Community based services through peer educators
- Strengthen ARSH clinics
- Roll out National Iron Plus initiative including weekly IFA Supplementation
- Promote Menstrual Hygiene

Health Systems Strengthening

- Case load based deployment of HR at all levels
- Ambulances, drugs, diagnostics, reproductive health commodities
- Health Education, Demand Promotion & Behavior Change Communication
- Supportive supervision and use of data for monitoring and review, including scorecards based on HMIS
- Public grievances redressal mechanism; client satisfaction and patient safety through all round quality assurance

Cross Cutting Interventions

- Bring down out of pocket expenses by ensuring, JSSK, RBSK and other free entitlements
- ANMs & Nurses to provide specialized and quality care to pregnant women and children
- Address social determinants of health through convergence
- Focus on un-served and underserved villages, urban slums and blocks
- Introduce difficult area and performance based incentives

5 x 5 Matrix for High Impact RMNCH+A Interventions

List of Minimum Essential Commodities

Reproductive Health

- FP Commodities; Tubal Rings, IUCD 380-A, IUCD 375
- Oral Contraceptive Pills (OCPs)/ (Mala-N), Condoms
- Emergency contraceptive Pills (ECP)- (Levonorgestrel 1.5 mg)
- Pregnancy Testing Kits (PTKS) Nischay
- Tablet Mifepristone & Tab Misoprostol (Only at facilities conducting Safe Abortion Services)

Maternal Health

- Injection Oxytocin
- Tablet Misoprostol
- Inj. Magnesium Sulphate
- Inj. TT
- Tab. Methyldopa
- Tab & Inj. Labetalol

Newborn Health

- Injection Vitamin K (1mg/ml)
- Vaccines-BCG, Oral Polio (OPV), Hepatitis B
- Mucous extractor

Child Health

- Oral Rehydration Salt (ORS)
- Zinc Sulphate Dispersible Tablets (10 mg & 20 mg)
- Syrup Salbutamol & Salbutamol nebulising solution
- Vaccines - DPT, Measles, BCG, Hepatitis B, OPV, TT, JE (selected districts), Pentavalent vaccine (selected states)
- Syrup Vitamin A
- Syrup Albendazole

Adolescent Health

- Tablet Albendazole
- Tablet Dicyclomine
- RTI/STI Kits

Cross Cutting Interventions as per level of facility

- Iron & Folic Acid (IFA) Tablet, IFA small tablet, IFA syrup ĉ Dispenser, Folic Acid (400 µg)
- Antibiotics : Ampicillin, Metronidazole, Amoxicillin, Trimethoprim & Sulphamethoxazole, Inj. Gentamicin, Inj. Ceftriaxone (Syr. / Cap. / Tab. / Inj. as applicable)
- Miscellaneous : Paracetamol, Chloroquin and Inj. Dexamethasone (Syr. / Tab. / Inj. as applicable)
- Clinical/Digital Thermometer, Weighting machine, BP apparatus, Stop Watch, Cold box, Vaccine carrier, Oxygen, Bag & Mask & MUAC (Mid Upper Arm Circumference) Tape
- Testing equipments for Haemoglobin, Urine and Blood Sugar, Hub cutter, Colour codes bins

Annexure 6.2

Socio – Cultural Barriers of Community and Home based Care, health care-seeking and care-givers behaviors in the continuum of care in Rajasthan

1. Pregnancy Care:

- During pregnancy the practice of not allowing mothers to go out in last the trimester is widely prevalent.
- Fear of surgical interventions - Pregnancy is regarded as being a 'natural' phenomenon (NFHS-1).
- Illness is often ascribed to supernatural powers and therefore seeking care from a trained provider is often delayed.
- Working will help in smooth delivery.
- Eat less or baby becomes heavy and there is danger in labor.
- Food taboos – traditional concepts of "hot" and "cold foods" leading to restriction in nutritious diet. Avoidance of eggs, milk, curds, green leafy vegetables, vitamin A rich fruits like papaya etc.
- There are several traditions prevailing among tribes about food intake by pregnant and lactating mother. The pregnant mother is prohibited to eat ghee, oil seeds, groundnuts, curd and hot foods.Newly delivered mother is given several types of herbal products and gum with ghee to eat. It is believed that during pregnancy rich foods containing ghee and fat is injurious to health of womb
- FLWs and service providers often perpetuate the beliefs - reasons for not taking adequate rest and extra diet during pregnancy by service providers it is not important, resources are not available, who will do the household works, there will be complications in pregnancy due to overeating, Work would aid in easy delivery

2. Child Birth : First 48 hrs at Facilities

- Service providers do not follow protocols for management of hypothermia or asphyxia in new born in facilities.
- Care providers might want to hasten labour so as to 'free up' labour-tables, maternity beds, and unburden the staff on duty.
- There could also be a problem of availability of skilled staff at birth in the facility. This could be a result of irrational deployment of HR in facilities at district/ sub district level.
- Families are also ignorant and want quick delivery and discharge from facilities -premature discharge after institutional deliveries would not allow the monitoring of the maternal and neonatal condition in the crucial first 24 hours after delivery. GOI issued administrative guidelines advising discharge after 48 hours. However, given care provider-preferences and family pressures alluded to above, compliance is still a challenge.
- High frequency of practices like applying fundal pressure, rampant use of oxytocin during labour, early bathing of the newborn, and early discharge from institutions render deliveries unsafe . (Messages: Importance of the natural progression of labour and on the need to avoid routinely speeding up the process through the use of manual compression and drugs and to avoid premature discharge is ignored).
- Give new born baby to family immediately
- Initiation of feeding colostrum and initiation of breastfeeding within 30 min-1 hr of birth is delayed or not followed. Feeding of prelacteals is common and also allowed by the staff. Belief that baby's first feed from mother should be given under the benign influence of stars and moonlight at night.

- Advice on giving bath to first bath to baby within 7 days often not given or followed
- Separating mother and new born in wards in facilities is also common

At Homes

- In domiciliary deliveries in the first few minutes, domiciliary birth attendants pay attention solely to the placenta and ignore the newborn to the extent that the baby is delivered directly onto the floor without someone receiving it. The first behavior of paying attention to the baby is not there- a newborn is often left lying on the ground until the placenta has been delivered. In some cultures the placenta is considered to have a soul, adding to the importance attached to its delivery.
- Another prevalent practice is bathing of the newborn within four hours of delivery, and the giving of prelacteal feeds "gutti" like honey and jaggery and discarding the colostrum. The belief is that the colostrum is dirty milk which has been in the mother's body for 9 months of pregnancy and so should be discarded.
- Tribal Bhil pregnant women work even upto ninth month of pregnancy. Immediately after the child's birth, the Bhil women feed, honey and Jaggary water to the baby, they believe it helps the child resist hunger. The child is usually put to breast a day after delivery.
- The tribal mother is given a small quantity of mahua liquor and water mixed with haldi (turmeric) and gour (Jaggary) for drinking for about 2 days. They think that these drinks will bring out all harmful substances from the body of the mother. Mothers are advised to avoid sour foods and green vegetables because they could adversely affect health of the mother and the child. The colostrum is discarded and the baby is breast fed after one day of delivery.

- Delaying the baby's first bath is important to prevent hypothermia and is the most challenging behavior - some communities attach ritual importance to the first bath or believe the baby should not be breastfed until after the bath.
- Some believe that an attendant (a TBA for example) has not done her job or is lazy if the baby is not bathed rather quickly.
- Local expectations about the bath can also negatively influence practices in facilities, even where providers have been taught appropriately.
- Keeping baby warm and dry and keeping baby with mother: Initial separation of mother and baby is common in some communities, however, and is often done mistakenly to protect the mother in some fashion.

3. Post-natal maternal and new born care :

- Traditional practices of seclusion and beliefs about the infant's vulnerability to various supernatural causes are major barriers. This makes skilled care to all women and newborns difficult.
- No trust in rural and tribal families on allopathic medicines – they are seen as not being appropriate for newborns.
- Deeply held concerns about taking the newborn out of the home- casting of evil eye, superstition etc.
- Problems of transportation is a reality in some remote areas
- Delay or resistance in seeking care from service providers or facilities in times of danger to both mother and baby
- In tribal community, illness and the consequent treatment is not always an individual and familiar affair, but the decision about the nature of treatment may be taken at the community level. In case of some specific diseases, not only the diseased person but also the total village community is affected. Health and treatment are very much connected with the environment.

Family new born care

- Low birth weight baby: babies are not weighed at birth and though families often recognize when a baby is small but do not pay enough attention.
- Families preoccupation with ceremonial community feasting and symbolic rituals inadvertently leading to ignoring new born baby
- Families have more time to act if there are tangible signs of infection. Infection (including acute respiratory infection — or pneumonia) remains a danger throughout the neonatal period. The key factor in treatment of infections is access—to a knowledgeable provider as well as to supplies. Babies with infections need to be treated with appropriate antibiotics

Home based care by FLWs:

Quality of service at facilities where 80% deliveries are taking place is also due to beliefs and motivations of service providers which often reinforce harmful practices and perpetuate prevalent social norms of mother and child care amongst families.

- FLWs home visits are irregular in the first 7, 14, 21, 28 days of the neonate period.
- Weak mentoring and supervisory support from supervisors
- Non-availability of Job aids for quality counseling services
- Non- functionary friendly job aids and kits- often cumbersome and not user friendly

Infant phase: 4-12 months

- Exclusive breast feeding not practiced – breast milk cannot support the child's nutritional needs and therefore supplementary feeds are required

- Baby has no teeth to chew food, solid food may cause diarrhea as baby cannot digest.
- Cultural restrictions on the meal size i.e. perception of amounts that should be fed to children at different ages is very small
- Concept of active feeding does not exist; majority of mothers never encourage their children to eat more
- Constraints in promoting energy dense gruels as they require cooking (fuel), foods not especially prepared for infants
- Link between diarrheal infections, contamination of water and foods given to babies not recognized
- Hand washing at critical times and feeding of baby not followed
- Babies excreta not harmful
- Continuity of feeding – breast milk and home based feeds during diarrhea not well understood
- Non Availability of zinc
- No knowledge on dosage regime for zinc to be followed during diarrhea.
- Water and sanitation must be improved, oral rehydration solutions need to be made more widely available, and zinc should be distributed to children with acute diarrhea.
- Facilities where very young children can be safely and effectively treated for diarrhea are severely limited and if parents cannot reach them in time, their children die. Even if they can get to the right place, managing illness in young children is not easy or cheap. And this is without counting the costs to parents having to travel to reach health care, pay for medicines and lose time at work, which cumulatively can push families into poverty

Annexure 6.3

Existing structure supporting to the SBCC strengthening system in the state

SBCC Strengthening System				
Position	**Sanctioned Post**	**Positioned**	**Vacant**	**Remark**
State Level Team				
Director-IEC	1	1		Administration, Additional Charge - Additional Mission Director (NRHM)
Joint Director-IEC	1	1	1	Administration support . Additional Charge of Project Director-(NRHM)
Dy Director-IEC	1	1		Charge to EPO
Asst Director-IEC	2	2		Media Management Support in Administration
Public Relation Officer	1	1		Extension Education
Total	**6**	**6**	**1**	
District Level Team				
Education Publicity Officer	40	4	36	District level IEC activity management , planning and monitoring
Dy Education Publicity Officer	64	1	63	District level IEC activity planning and execution
Health Educator	33	4	29	Health Counselling and IEC activity execution
Total	**137**	**9**	**128**	
Block Level Team				
Block Health supervisor	265	11	254	Village level IEC activity sup ervision and execution
Overall status	**408**	**26**	**383**	
Consultant				
Consultant-IEC	1	1	0	State level IECactivity planning and execution
District IEC Coordinator	34	20	14	District level IEC activity planning, execution and monitoring
Total Consultant Status	**35**	**21**	**14**	
Overall status	**443**	**47**	**397**	

Government Order for re-designation of ASHA Cadre as IEC

Annexure 6.4

Checklist for Monitoring Visits

Monitoring Format For Block Monitors for HH visit by ASHA/ AWW				
1	Which health workers visited your HH during last 4 months? How many times and why? (multiple response)			
	Designation of Health Workers	No. of times	Reason of Visit	
	ASHA			
	AWW			
	ANM			
	Other			
2	Who made the visit last of all?			
3	When was the last visit made?			
4	Please elaborate on her last visit?			
5	Did you understand what she said/done? If no, Why not?			
6	Did she use/ bring any communication/explanation material/equipment What and Why			
7	Did use of the..... helped understanding?			
8	Did she talk to other members also? Whom and about What?			
9	Did you try doing what she asked you? Yes/No, Why?			
10	Would you continue doing it? Yes/No, Why?			

For MCHN Day			
1	Which health workers were present on MCHN Day and what were they doing?		
	Designation of Health Workers	Conducting/involved in	
	ASHA		
	AWW		
	ANM		
	Other		
2	Why have you gone for MCHN Day?		
	1.ANC 2.Immunization of Child 3. Weighing of child 4. SNP 5. Other.....		
3	Who provided you the services?		
	1.ANC checkup		
	2. TT		
	3.Immunization of Child		
	4. Weighing of child		
	5. SNP		
	6. Other.....		

4	Please tick mark the type of services you got for each category				
	ANC checkup	Immunization	Weighing	SNP for child	
	BP	Told about Fever	Weighed the baby	Gave THR	
	Hb	Gave medicine for fever	Informed about weight gained or lost	Explained/ reiterated how to prepare	
	Weight	Told about follow-up	Plotted on a graph	No of times to be given	
	Abdominal Examination		Explained the growth		
	Checked on Swelling in feet		Counselled on actions to be taken		
	Advice on Diet				
	Counselling				
5	Did you attend any meeting/session on MCHN Day? If No, Why not				
6	What was the meeting about? (Theme)				
7	Did she use/ bring any communication/explanation material? What were those?				
8	Did use of the..... helped understanding?				
9	Do you approve of what was explained? If No, Why				
10	Did you try following what was explained? Yes/No, Why?				
11	Would you continue doing it? Yes/No, Why?				
12	Why other women are not doing this? What should be done to convince them?				

For Adolescents				
1	Which health workers met /visited you in last three months? When and Why?			Codes
	Designation of Health Workers	When	Why	
	ASHA			
	AWW			
	ANM			
	Other			
2	Did you attend any meeting of adolescents? When? Home many participated in it			
3	What was discussed in that?			
	1.Iron Deficiency induced anemia			
	2. WIFS			
	3.Snaitation and Hygiene			
	4. Menstrual Hygiene-Use of napkins			
	5. Menstrual Hygiene-Use of Clean cloth			
	6. ARSH			
	7. Cooking Method			
	7. Others			
4	How were these things explained?			
	Counselling			
	Video			
	Mobile			
	Flash Card			
	Z Card			
	Short movie			
	Other			

5	Did use of the..... helped understanding?	
6	Which method you liked best? Why?	
7	Do you approve of what was explained? If No, Why	
8	Would you be able to do what was explained? If no, Why	
9	Did you try following what was explained? Yes/No, Why?	
10	Would you continue doing it? Yes/No, Why?	
11	Why other adolescent girls are not doing this? What should be done to convince them?	
12	Did you attend any meeting/session on the same issues in school? If Yes, When?	

Annexure 6.5

SBCC Strategy: Sample District Plan

Rajasthan is the largest state of India where 5.5 percent of total population resides and 7 percent of total live births occur. It is also home to around 10 percent of total maternal deaths, 7 percent of infant and 8 percent of newborns deaths of the country.

The achievement of Millennium Development Goal 3 and 4 and CTA (Call To Action) goals seems un uphill struggle. An analysis of the situation of the state shows that some of the districts are performing lesser than other districts and therefore the overall performance of the state on the key indicators is far below the national status.

On the basis of the performance on select parameters related to maternal and child health, family planning and disease control, 10 districts have been prioritized in terms of need of immediate action and are called High Priority Districts. They are - Banswada, Barmer, Bundi, Dholpur, Dungarpur Jalore, Jaiselmer, Karoli, Rajsamnd and Udaipur.

CTA strategy of Rajasthan encompasses high impact interventions across the life cycle based on the 'continuum of

care' linking community and facility based care as well as referrals between various levels of health care system. In the 10 identified HPDs, the interventions at various points in the continuum with high impact interventions have been prioritised.

Corresponding to the high impact interventions, 16 dash board indicators as recommended in RMNCH+A have been identified to monitor and track the progress of the interventions. The status of indicators is to a great extent reflection of the strength of human resource. The tables below shows the status of different types of staff in the 10 HPDs

Table 1: Percentage vacancies of MOs by number of positions sanctioned and vacant positions by 10 HPDs

S.No	District Name	Positions sanctioned	Vacant Positions (%)
1.	Rajasmand	53	56.60
2.	Dungarpur	76	53.95
3.	Jaisalmer	39	53.85
4.	Jalore	21	38.09
5.	Dhaulpur	56	35.71
6.	Banswara	66	27.27
7.	Barmer	71	26.76
8.	Karauli	35	25.71
9.	Bundi	49	16.33
10.	Udaipur	109	12.84

Table 2: Deployment of Gynecologists in urban and rural area

S. No.	District Name	Position of Gynecologists					
		Total Sanctioned positions	Rural sanctioned (%)	Urban sanctioned (%)	Total Filled position	Rural filled (%)	Urban filled (%)
1.	Dhaulpur	8	12.5	87.5	4	0	100
2.	Karauli	8	25	75	5	0	100
3.	Barmer	10	20	80	2	0	100
4.	Jaisalmer	7	57.14	42.86	3	0	100
5.	Jalore	9	22.22	77.78	1	0	100
6.	Bundi	9	11.11	88.89	2	0	100
7.	Banswara	11	54.55	45.45	3	33.33	66.67
8.	Dungarpur	11	36.36	63.66	4	0	100
9.	Rajasmand	10	20	80	2	0	100
10.	Udaipur	17	35.29	64.71	11	27.27	72.72

[1]Source: Directorate of health and family Welfare, 2012

Table 3: Deployment of Paediatricians in urban and rural area

S. No.	District Name	Position of Paediatricians					
		Total Sanctioned positions	Rural sanctioned (%)	Urban sanctioned (%)	Total Filled position	Rural filled (%)	Urban filled (%)
1.	Dhaulpur	6	16.67	83.33	1	0	20
2.	Karauli	6	16.67	83.33	4	0	80
3.	Barmer	10	20	80	4	0	50
4.	Jaisalmer	5	40	60	2	0	66.67
5.	Jalore	8	12.5	87.5	4	0	57.14
6.	Bundi	7	14.29	85.71	4	0	66.67
7.	Banswara	8	50	50	3	0	75
8.	Dungarpur	11	27.27	72.73	1	0	12.5
9.	Rajasmand	9	22.22	77.78	4	0	57.14
10.	Udaipur	12	33.33	66.67	7	75	50

Table 4: Deployment of Anaesthestists in urban and rural area

S. No	District Name	Position of Anaesthetists					
		Total Sanctioned positions	Sanctioned in rural areas (%)	Sanctioned in urban areas (%)	Total positions filled	Rural filled (%)	Urban filled (%)
1.	Dhaulpur	8	12.5	87.5	3	0	100
2.	Karauli	7	14.29	85.71	3	0	100
3.	Barmer	7	28.57	71.43	3	0	100
4.	Jaisalmer	5	40	60	1	0	100
5.	Jalore	6	0	100	2	0	100
6.	Bundi	8	12.5	87.5	5	20	80
7.	Banswara	9	33.33	66.67	3	33.33	66.67
8.	Dungarpur	7	14.28	85.71	2	0	100
9.	Rajasmand	9	22.22	77.78	1	0	100
10.	Udaipur	11	18.18	81.81	6	33.33	66.67

Table 5: District wise posts of nursing staff sanctioned by the state and percent vacant positions

S. No	District	Nurse Grade 1		Nurse Grade 2		ANM		LHV	
		Sanctioned	% vacant	Sanctioned	% vacant	Sanctioned	% vacant	Sanctioned	% vacant
1.	Barmer	43	23.3	317	10.4	648	14.5	78	39.7
2.	Jaisalmer	17	41.2	141	43.9	180	12.8	19	57.9
3.	Jalore	27	37.0	204	0.5	467	6.6	70	28.6
4.	Bundi	36	19.4	189	17.9	236	3.8	30	6.7
5.	Dhaulpur	28	35.7	170	23.5	247	4.5	27	3.7
6.	Karauli	28	10.7	178	10.7	301	8.6	30	10
7.	Udaipur	1`66	12.7	849	20.8	732	7.4	92	16.3
8.	Rajsamand	35	51.4	253	38.3	278	5.7	46	13
9.	Dungarpur	40	17.5	257	10.1	418	5.5	59	27.1
10.	Banswara	59	5.1	308	12.3	501	8.9	67	17.9

While the state is strengthening various service delivery mechanisms-filling up the vacant positions and infrastructure requirements, there is an urgent need to need to simultaneously mobilize communities to ensure access and utilization of services.

Social and Behaviour Change Communication (SBCC) Strategy attempts to plan the communication activities which matches the need of the district , locally suitable and are also in sync to the overall state strategy.

Based on formative research conducted in the state and primary data and some indicators reflected in AHS 2011-12 there are few areas need to be addressed through SBCC. Core issues and areas are

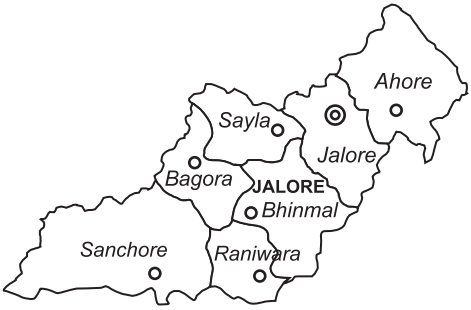
- Age at first pregnancy ,Registration of Pregnancy and ANC Check up, diet, IFA, TT Immunization etc, Birth Preparedness
- Place of delivery, Post Natal Care, Post partum Family planning
- New Born Care, Growth Monitoring and Child Immunization

Bottleneck analysis was conducted in HPDs to identify socio-cultural determinants of home-based care. Table 6 presented lists down the barriers across the life stages of RMNCH+A.

Table 6: Socio– Cultural Determinants of Community and Home based Care, in Rajasthan

Pregnancy Care:	Child Birth: First 48 hrs at Facilities	Post-natal maternal and new born care :	Infant phase: 4-12 months
Not allowing mothers to go out in last the trimester. Illness is often ascribed to supernatural powers and therefore seeking care is often delayed	Families are ignorant and want quick discharge from facilities after delivery (Before 48 Hour)	Traditional practices of seclusion and beliefs about the infant's vulnerability to various supernatural causes are major barriers. This makes skilled care to all women and newborns difficult	Exclusive breast feeding not practiced – breast milk cannot support the child's nutritional needs and therefore supplementary feeds are required
Eat less or baby becomes heavy and there is danger in labor	High frequency of practices like applying fundal pressure, rampant use of oxytocin during labour, early bathing of the newborn,. Give new born baby to family immediately	Deeply held concerns about taking the newborn out of the home- casting of evil eye, superstition etc.	Baby has no teeth to chew food, solid food may cause diarrhea as baby cannot digest majority of mothers never encourage their children to eat more
Food taboos – traditional concepts of "hot" and "cold foods" leading to restriction in nutritious diet. Avoidance of eggs, milk, curds, green leafy vegetables, vitamin A rich fruits like papaya etc.	Initiation of feeding colostrum and initiation of breastfeeding within 30 min-1 hr of birth is delayed or not followed. Feeding of prelacteals is common and also allowed by the staff.	Delay or resistance in seeking care from service providers or facilities in times of danger to both mother and baby	Link between diarrheal infections, contamination of water and foods given to babies not recognized
The pregnant mother is prohibited to eat ghee, oil seeds, groundnuts, curd and hot foods. It is believed that during pregnancy, rich foods is injurious to health of womb	Advice on giving bath to first bath to baby within 7 days often not given or followed	Low birth weight baby: babies are not weighed at birth and though families often recognize when a baby is small but do not pay enough attention.	Hand washing at critical times and feeding of baby not followed
	Separating mother and new born in wards in facilities is also common	Families preoccupation with ceremonial community feasting and symbolic rituals inadvertently leading to ignoring new born baby	Babies excreta not harmful
	Bathing of the newborn within four hours of delivery, and the giving of prelacteal feeds "gutti" like honey and jaggery and discarding the colostrum is common	The key factor in treatment of infections is access—to a knowledgeable provider as well as to supplies. Babies with infections need to be treated with appropriate antibiotics	Continuity of feeding – breast milk and home based feeds during diarrhea not well understood

District Profile: Jalore



Jalore has been divided into nine sub-units-Ahore, Jalore, Sayla, Bhinmal, Bagora, Raniwara, Jaswantpura, Chitalwana and Sanchore. There are 804 revenue villages in the district. For revenue administration, Jalore, Ahore, Bhinmal, Jaswantpura, Raniwara, Sanchore, Chitalwana, Sayala and Bagoda had been provided with Tehsil Officer whereas Bhadrajun, Ramseen and Jeevana have Sub-Tehsil Office.

For proper functioning of developmental activity Eight Panchayat Samiti Office have been established at Jalore, Ahore, Bhinmal, Raniwara, Sanchore, Sayala, Jaswantpura and Chitalwana .Three Municipalities are situated at Jalore, Bhinmal, Sanchore.

For instituting Democratic laws of governance Jalore-Sirohi is jointly one parliamentary constituency. There are five legislative assembly areas namely Jalore, Ahore, Bhinmal, Raniwara, Sanchore Members of Lok Sabha legislative assembly.

Administrative setup

Items	No.
Subdivision	9
Tehsil	9
Sub Tehsil	3
Development Blocks	8
Census town	4
Panchayat Samiti	8
Gram Panchyat	264
Revenue village	804

Provisional Population Statistics of the district 2011

Details	2011 (As per)
Total Population	1830151
Males	937918
Females	892233
Percentage Decadal Growth 2001-2011	26.31
Sex Ratio	951
Density (persons per sq. km.)	172
Child Sex Ratio (0-6 Years)	891
Literacy rate Persons	55.58%
Literacy rate Females	38.73%

Table 7: Tehsilwise Population Statistics - Census 2011

S.No.	Tehsil	Rural/ Urban	Total Population			Literates/Literacy Rate		
			Persons	Sex Ratio	Sex Ratio 0-6 age group	Total	Male	Female
1	Bhinmal	Total	302770	972	884	54.42	71.56	37.15
2	Sanchore	Total	487651	918	886	56.97	72.97	39.68
3	Jalore	Total	264653	949	889	57.58	73.40	41.12
4	Sayla	Total	176824	960	890	50.62	67.44	33.39
5	Ahore	Total	240081	1011	890	60.07	75.47	45.18
6	Raniwara	Total	206871	940	891	53.76	70.08	36.59
7	Bagora	Total	151301	935	918	50.71	67.53	32.81

Table 8 shows the performance of Jalore on 16 indicators. While the entire district needs to improve on the parameters, an analysis of the data shows that the blocks of Jalore are not at equal platform.

Specifically, in view of priority the following high impact behaviours need to be addressed as per the information

- ANC Registration with in
  1st Trimester- All the blocks
- Preg. women received 3 ANC check-ups-All the blocks
- Institutional deliveries-All the block except Sayla and Bheenmal
- % of Infants immunized by Measles-Sanchore and Syala

- Newborns weighing More than 2.5 kg- All the Blocks
- Newborns visited within 24hrs of home delivery- Bheenmal
- Women Stay 48 hrs and more after delivery in public institutions-Bheenmal, Sanchore, Jaswantpura, Sayla

Table 8: RMNCH+A 16 Dashboard Indicators of Jalore (Based on report submitted to state from April 2013 to March 2014)

Dashboard Indicators	District/ Block	Jalore	Ahore	Bhinmal	Chitalwana	Jalore	Jaswantpura	Raniwara	Sanchore	Sayla
1	ANC Registration with in 1st Trimester	39.2	42.56	36.79	35.26	32.98	37.86	43.08	35.43	34.66
2	Preg. women received 3 ANC check-ups	63.92	62.01	63.6	56.95	66.66	61.36	71.19	62.01	57.81
3	Pregnant women given 100 IFA	81.4	77.57	86.19	72.88	80.86	93.05	75.52	74.78	76.52
4	Pregnant women with Obstetric Complications and attended	14.88	13.49	14.79	0	4.14	0.23	0	65.36	3.47
5	Pregnant women receiving TT2 or Booster	80.24	81.45	86.05	67.34	84.54	86.92	85.23	76.47	76.56
6	SBA attended home deliveries	44.78	45.71	42	26.36	43.36	61.07	64.94	22.95	59.81
7	Institutional deliveries	79.38	44.92	152.37	47.09	38.53	44.99	61.15	131.45	37.9
8	C-Section	2.43	0	10.3	0	0.77	0	0	4.62	0.18
9	Newborns breast fed within 1 hour	99.03	100.4	99.6	99.06	90.55	94.78	99.62	99.44	100
10	Women Stay 48 hrs and more after delivery in public institutions	67.79	82.56	58.46	100	74.96	49.43	53.68	24.36	68.11
11	Newborns weighing More than 2.5 kg	58.54	56.64	48.08	30.43	28.21	36.99	96.21	66.48	96.52
12	Newborns visited within 24hrs of home delivery	86.59	80.49	68	97.35	66.41	70.9	97.4	86.2	99.53
13	% of Infants immunized by Measles	82.84	82.87	87.05	80.83	84.84	85.61	89.39	76.35	76.65
14	Post-partum sterilization	28.49	7.45	72.7	35.14	21.4	8.31	22.83	35.25	7.84
15	Male sterilization	2.52	1.82	0	0	0	0	13.89	0.97	0
16	IUD insertions	94.32	110.74	92.31	108.87	105.75	101.1	90.62	105.36	71.48

SBCC Strategy

The SBCC intervention with respect to RMNCH+A would be specific and focused on improving the status of 16 health parameters There is a need to follow a systematic communication strategy which includes –IPC, Social mobilization, Advocacy along with backup support of mass media.

IPC: Many of the home-based behaviours have been identified which needs to be corrected. The front line workers would be required to be trained in IPC and use of communication materials as aids so that they could counsel the target audience for desired behaviours.

Social Mobilization: For outreach, social mobilization including engagement of children via rallies, meetings and small group discussions of women, adolescents or community members on MCHN day would be conducted.

Advocacy: Advocacy would be required at two levels. One is with the management to fill the vacant positions of health staff or plan some alternative so that services are available to the rural population. Secondly, advocacy will be done with the key informants, influencers at the block and village level so that desired behaviours at the community level could be ensured. To make media and management of different department sensitive to the status and barriers faced in achieving each behaviour, advocacy would be done through media advocacy workshops and meetings.

Mass media would be used for general community primarily for reinforcing the messages. Knowledge has emerged as more of an issue with respect to neo natal and child health. Greater use of mass media would be for done for informing community on knowledge of danger sings with respect to neonatal and child health and perceived severity and susceptibility.

Mid-media including street play would be conducted at the block level to generate interest and deliver messages through messages interwoven in stories and through different characters of the play. This would be primarily for reproductive and maternal health.

SOPs would be developed at the state level and circulated to the delivery points so that nursing staff at the facility level could ensure that the desired behaviour is conducted by the beneficiary.

Planning and Implementation

State level Responsibilities

- Mass-media initiatives would be planned, designed and implemented by the state level office-IEC bureau and SIHFW with support of the development partners.
- State would conduct training for capacity building of the Master-trainers for the district and plan the training to be conducted at the district and block level.
- State would provide improved communication aids to be used for by frontline workers.
- Use of technology-driven communication aids like mobile, tablets and videos would be planned and implemented if found feasible
- State Officials will advocate the issues with the management for filling up the vacant positions, rational deployment of the health staff across the districts.

District Level Responsibilities

- District level officials would take care of the mid-media activities to be conducted in different blocks
- District officials would oversee the execution of training y Master trainers
- District Officials will advocate the issue with the media for

adequate coverage and sensitive and reporting which supports health-seeking behavior

- In case of shortage of staff or vacant positions, district officials will advocate for use of mobile vans for health promotion
- Handholding of the front line workers on continuous basis
- Advocacy with village level influencers, Sarpanch, members of VHSC Committee and other stakeholders for participation in support of frontline workers
- Supporting Front line workers in social mobilization activities at school, community meetings, youth clubs, rallies, SHG meetings for creating enabling environment

Monitoring and Corrective Action

Monitoring would be the key to successful implementation of SBCC interventions.

- All the monitoring bodies from State to Block level would use the single approved format for assessing the effect of SBCC interventions in terms of reach and coverage, skill of the workers in IPC and use of communication Aids. The corrective measures will be suggested and follow-up would be done by the immediate supervisors on regular basis.

Below is presented block-level SBCC Plan. The interventions could be implemented in phased manner. The health indictors which require utmost attention has been prioritized and only those have been taken to be emphasized. As they show improvement, the other parameters could be taken up. In case, some block level barriers had been identified, the same could be addressed through the proposed strategy. State and district level officials will guide implementation of any additional SBCC measures or required support.

Block Level SBBC Plan (Ahore)									
Desired Behaviour– Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Pregnancy									
• ANC Registration with in 1st Trimester	Woman and MIL	Taboo to disclose pregnancy	To sensitize on early registration	IPC	Communication Aids	Supply of Nichay kit	Confidentiality of information to be ensured	HH hold visits and women/ families counselled	ASHA Facilitator
• Preg. women received 3 ANC check-ups	Woman, Spouse, MIL, Community	Pregnancy considered a routine activity Son preference	To approve that pregnancy needs extra care and close monitoring	IPC Advocacy Mass Media	Mobile Device (Any visual aid for effectiveness)	All functional instruments	Regularity of MCHN Day, Availability of ANM All test to be conducted and need-based counselling	Women received 3+ ANC	ASHA Facilitator

Desired Behaviour – Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Delivery									
Institutional deliveries	Woman, MIL, Spouse	Low pregnancy preparedness Unavailability of transport Prefer home deliveries	To increase realization of importance of birth preparedness To facilitate institutional deliveries To increase approval of importance of institutional delivery/delivery by skilled health person	IPC Social Mobilization		24* 7 health facilities – Accessibility and availability		Institutional Deliveries	ASHA Facilitator
Women Stay 48 hrs and more after delivery in public institutions	Women, MIL Nursing Staff	Dangers of post-partum not known No play for the attendants to stay Staff not strict on adhering to the norm	To provide knowledge on dangers	IPC Social Mobilization Advocacy	Flash cards Video Mobile device (message/clipping) SOPs for Health Staff	Adequate Infrastructure to bear patient load	Provision of Stay arrangement of attendants	Increase in the proportion of women who stayed for 48 hours or more after delivery Decrease in number of postpartum complications	ASHA Facilitator, ASHA Coordinator

Desired Behaviour-Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
New-Born/Child Care									
Newborns weighing More than 2.5 kg	Woman, MIL Community Health Workers	Anaemic mother Weighing not preferred culturally All children are not weighed Importance of weighing and its link to health not well understood	To increase knowledge and intention to weigh baby To approve of better and balanced diet during pregnancy with IFA	IPC Advocacy Social Mobilization	Video on growth of child and its relation to weight SOPs for Health Staff	Functional Instruments	Positive Deviants could be used	Increase in proportion of children weighing more than 2.5 Kg Increase in proportion of mothers who received need-based counselling on weighing and know whether the child was under weight	
Reproductive									
Post-partum sterilization	Woman, Spouse MIL	Do not appreciate importance of sterilization just after delivery	To increase acceptance of post partum sterilization	IPC	Flip Book SOPs	Quality of Services	Health Staff to counsel after delivery	Increase in proportion of woman who opted for Post partum Sterilization	ASHA Facilitator ASHA Coordinator

		Have fear of the two things coming together Newly delivered Child's well-being is a concern							
Male sterilization	Man	Stigma attached Apprehension about sexual life Do not think it is man's job	To accept sterilization is couple's responsibility To appreciate that sterilization for males is easier and pain free compared to females To realize and accept male sterilization doesn't hinder sexual life	Mid media Print Media Advocacy	Street Play Flash cards Role Models	Quality services	Counselling post sterilization	Increase in proportion of male sterilization	ASHA facilitator ASHA Coordinator

Block lock Level SBBC Plan (Bhinmal)									
Desired Behaviour – Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Pregnancy									
ANC Registration with in 1st Trimester	Woman and MIL	Taboo to disclose pregnancy	To sensitize on early registration	IPC	Communication Aids	Supply of Nichay kit	Confidentiality of information to be ensured	HH hold visits and women/ families counselled	ASHA Facilitator
Preg. women received 3 ANC check-ups	Woman, Spouse, MIL, Community	Pregnancy considered a routine activity Son preference	To approve that pregnancy needs extra care and close monitoring	IPC Advocacy Mass Media	Mobile Device (Any visual aid for effectiveness)	All functional instruments	Regularity of MCHN Day, Availability of ANM All test to be conducted and need-based counselling	Women received 3+ ANC	ASHA Facilitator

Desired Behaviour – Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Delivery									
Pregnant women with Obstetric Complications and attended	Woman, Spouse, MIL	Low awareness of danger sign and delay in seeking care Delay at the health facility	To increase knowledge of the danger signs	IPC	Flip Book	Functional 24*7 Health services Prompt services		Woman timely attended to	ASHA Coordinator / ASHA Facilitator
SBA attended home deliveries	Woman, MIL, Spouse	Low pregnancy preparedness Unavailability of transport Prefer home deliveries	To increase realization of importance of birth preparedness To facilitate institutional deliveries To increase approval of importance of institutional delivery/delivery by skilled health person	IPC Social Mobilization		Availability of Skilled Birth Attendant 24* 7 health facilities		Women delivered by SBA Institutional Deliveries	ASHA Facilitator

Desired Behaviour – Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Women Stay 48 hrs and more after delivery in public institutions	Women, MIL Nursing Staff	Dangers of post-partum not known No play for the attendants to stay Staff not strict on adhering to the norm	To provide knowledge on dangers	IPC Social Mobilization Advocacy	Flash cards Video Mobile device (message/clipping) SOPs **for Health Staff**	Adequate Infrastructure to bear patient load	Provision of Stay arrangement of attendants	Increase in the proportion of women who stayed for 48 hours or more after delivery Decrease in number of postpartum complications	ASHA Facilitator, ASHA Coordinator
New-Born/Child Care									
Newborns weighing More than 2.5 kg	Woman, MIL Community Health Workers	Anaemic mother Weighing not preferred culturally All children are not weighed Importance of weighing and its link to health not well understood	To increase knowledge and intention to weigh baby To approve of better and balanced diet during pregnancy with IFA	IPC Advocacy Social Mobilization	Video on growth of child and its relation to weight SOPs for Health Staff	Functional Instruments	Positive Deviants could be used	Increase in proportion of children weighing more than 2.5 Kg Increase in proportion of mothers who received need-based counselling on weighing and know whether the child was under weight	

Desired Behaviour – Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Newborns visited within 24hrs of home delivery	Woman, MIL Community Health Workers	Women who delivers doesn't meet outsiders Health workers do not negotiate and avoid checking the symptoms	To increase proportion of people who appreciate care after delivery	IPC Social mobilization	Visual Aid (Flip Book) Checklist on symptoms	Orientation of the workers on their knowledge of symptoms on regular basis	Handholding by Medical staff if ASHA/AWW is making the home visit	Increase in proportion of woman visited by health staff with 24 hours	ASHA Facilitator ASHA Coordinator
Reproductive									
Post-partum sterilization	Woman, Spouse MIL	Do not appreciate importance of sterilization just after delivery Have fear of the two things coming together Newly delivered Child's well-being is a concern	To increase acceptance of post partum sterilization	IPC	Flip Book SOPs	Quality of Services	Health Staff to counsel after delivery	Increase in proportion of woman who opted for Post partum Sterilization	ASHA Facilitator ASHA Coordinator

Desired Behaviour – Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Male sterilization	Man	Stigma attached Apprehension about sexual life Do not think it is man's job	To accept sterilization is couple's responsibility To appreciate that sterilization for males is easier and pain free compared to females To realize and accept male sterilization doesn't hinder sexual life	Mid media Print Media Advocacy	Street Play Flash cards Role Models	Quality services	Counselling post sterilization	Increase in proportion of male sterilization	ASHA facilitator ASHA Coordinator

Block lock Level SBBC Plan (Chitalwana)									
Desired Behaviour - Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Pregnancy									
ANC Registration with in 1st Trimester	Woman and MIL	Taboo to disclose pregnancy	To sensitize on early registration	IPC	Communication Aids	Supply of Nichay kit	Confidentiality of information to be ensured	HH hold visits and women/ families counselled	ASHA Facilitator
Preg. women received 3 ANC check-ups	Woman, Spouse, MIL, Community	Pregnancy considered a routine activity Son preference	To approve that pregnancy needs extra care and close monitoring	IPC Advocacy Mass Media	Mobile Device (Any visual aid for effectiveness)	All functional instruments	Regularity of MCHN Day, Availability of ANM All test to be conducted and need-based counselling	Women received 3+ ANC	ASHA Facilitator

Desired Behaviour-Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Delivery									
SBA attended home deliveries Institutional deliveries	Woman, MIL, Spouse	Low pregnancy preparedness Unavailability of transport Prefer home deliveries	To increase realization of importance of birth preparedness To facilitate institutional deliveries To increase approval of importance of institutional delivery/delivery by skilled health person	IPC Social Mobilization		Availability of Skilled Birth Attendant 24* 7 health facilities		Women delivered by SBA Institutional Deliveries	ASHA Facilitator

New-Born/Child Care									
Desired Behaviour - prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Newborns weighing More than 2.5 kg	Woman, MIL Community Health Workers	Anaemic mother Weighing not preferred culturally All children are not weighed Importance of weighing and its link to health not well understood	To increase knowledge and intention to weigh baby To approve of better and balanced diet during pregnancy with IFA	IPC Advocacy Social Mobilization	Video on growth of child and its relation to weight SOPs for Health Staff	Functional Instruments	Positive Deviants could be used	Increase in proportion of children weighing more than 2.5 Kg Increase in proportion of mothers who received need-based counselling on weighing and know whether the child was under weight	
% of Infants immunized by Measles	Mothers MIL Community	Importance of immunization not appreciated Discomfort to the child is avoided	To increase proportion of people who realize importance of immunization over discomfort	IPC Mass media Social mobilization	Videos Visual Aids	Due list to be prepared Systematic procedure to identify children so that neither	Vaccines Conduction of MCHN Day Mobile Services in case of non-availability of	Increase in proportion of children immunized	ASHA Facilitator ASHA Coordinator

		Services not provided every time- depended on no of children available Due list not prepared for correct identification				vaccine goes waste nor care givers have to wait	staff		
Desired Behaviour - Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Reproductive									
Post-partum sterilization	Woman, Spouse MIL	Do not appreciate importance of sterilization just after delivery Have fear of the two things coming together Newly delivered Child's well-being is a concern	To increase acceptance of post partum sterilization	IPC	Flip Book SOPs	Quality of Services	Health Staff to counsel after delivery	Increase in proportion of woman who opted for Post partum Sterilization	ASHA Facilitator ASHA Coordinator

Male sterilization	Man	Stigma attached Apprehension about sexual life Do not think it is man's job	To accept sterilization is couple's responsibility To appreciate that sterilization for males is easier and pain free compared to females To realize and accept male sterilization doesn't hinder sexual life	Mid media Print Media Advocacy	Street Play Flash cards Role Models	Quality services	Counselling post sterilization	Increase in proportion of male sterilization	ASHA facilitator ASHA Coordinator

Block lock Level SBBC Plan (Jalore)									
Desired Behaviour - Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Pregnancy									
ANC Registration with in 1st Trimester	Woman and MIL	Taboo to disclose pregnancy	To sensitize on early registration	IPC	Communication Aids	Supply of Nichay kit	Confidentiality of information to be ensured	HH hold visits and women/ families counselled	ASHA Facilitator
Preg. women received 3 ANC check-ups	Woman, Spouse, MIL, Community	Pregnancy considered a routine activity Son preference	To approve that pregnancy needs extra care and close monitoring	IPC Advocacy Mass Media	Mobile Device (Any visual aid for effectiveness)	All functional instruments	Regularity of MCHN Day, Availability of ANM All test to be conducted and need-based counselling	Women received 3+ ANC	ASHA Facilitator

Desired Behaviour - Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Delivery									
SBA attended home deliveries Institutional deliveries	Woman, MIL, Spouse	Low pregnancy preparedness Unavailability of transport Prefer home deliveries	To increase realization of importance of birth preparedness To facilitate institutional deliveries To increase approval of importance of institutional delivery/delivery by skilled health person	IPC Social Mobilization		Availability of Skilled Birth Attendant 24* 7 health facilities		Women delivered by SBA Institutional Deliveries	ASHA Facilitator

Desired Behaviour - Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
New-Born/Child Care									
Newborns weighing More than 2.5 kg	Woman, MIL Community Health Workers	Anaemic mother Weighing not preferred culturally All children are not weighed Importance of weighing and its link to health not well understood	To increase knowledge and intention to weigh baby To approve of better and balanced diet during pregnancy with IFA	IPC Advocacy Social Mobilization	Video on growth of child and its relation to weight SOPs for Health Staff	Functional Instruments	Positive Deviants could be used	Increase in proportion of children weighing more than 2.5 Kg Increase in proportion of mothers who received need-based counselling on weighing and know whether the child was under weight	
Newborns visited within 24hrs of home delivery	Woman, MIL Community Health Workers	Women who delivers doesn't meet outsiders Health workers do not negotiate and avoid checking the symptoms	To increase proportion of people who appreciate care after delivery	IPC Social mobilization	Visual Aid (Flip Book) Checklist on symptoms	Orientation of the workers on their knowledge of symptoms on regular basis	Handholding by Medical staff if ASHA/AWW is making the home visit	Increase in proportion of woman visited by health staff with 24 hours	ASHA Facilitator ASHA Coordinator

Desired Behaviour - Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Reproductive									
Post-partum sterilization	Woman, Spouse MIL	Do not appreciate importance of sterilization just after delivery Have fear of the two things coming together Newly delivered Child's well-being is a concern	To increase acceptance of post partum sterilization	IPC	Flip Book SOPs	Quality of Services	Health Staff to counsel after delivery	Increase in proportion of woman who opted for Post partum Sterilization	ASHA Facilitator ASHA Coordinator
Male sterilization	Man	Stigma attached Apprehension about sexual life Do not think it is man's job	To accept sterilization is couple's responsibility To appreciate that sterilization for males is easier and pain free compared to females To realize and accept male sterilization doesn't hinder sexual life	Mid media Print Media Advocacy	Street Play Flash cards Role Models	Quality services	Counselling post sterilization	Increase in proportion of male sterilization	ASHA facilitator ASHA Coordinator

Block lock Level SBBC Plan (Jaswantpura)									
Desired Behaviour - Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Pregnancy									
ANC Registration with in 1st Trimester	Woman and MIL	Taboo to disclose pregnancy	To sensitize on early registration	IPC	Communication Aids	Supply of Nichay kit	Confidentiality of information to be ensured	HH hold visits and women/ families counselled	ASHA Facilitator
Preg. women received 3 ANC check-ups	Woman, Spouse, MIL, Community	Pregnancy considered a routine activity Son preference	To approve that pregnancy needs extra care and close monitoring	IPC Advocacy Mass Media	Mobile Device (Any visual aid for effectiveness)	All functional instruments	Regularity of MCHN Day, Availability of ANM All test to be conducted and need-based counselling	Women received 3+ ANC	ASHA Facilitator

Desired Behaviour - Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Delivery									
SBA attended home deliveries Institutional deliveries	Woman, MIL, Spouse	Low pregnancy preparedness Unavailability of transport Prefer home deliveries	To increase realization of importance of birth preparedness To facilitate institutional deliveries To increase approval of importance of institutional delivery/delivery by skilled health person	IPC Social Mobilization		Availability of Skilled Birth Attendant 24* 7 health facilities		Women delivered by SBA Institutional Deliveries	ASHA Facilitator
Women Stay 48 hrs and more after delivery in public institutions	Women, MIL Nursing Staff	Dangers of post-partum not known No play for the attendants to stay Staff not strict on adhering to the norm	To provide knowledge on dangers	IPC Social Mobilization Advocacy	Flash cards Video Mobile device (message/clipping) SOPs for Health Staff	Adequate Infrastructure to bear patient load	Provision of Stay arrangement of attendants	Increase in the proportion of women who stayed for 48 hours or more after delivery Decrease in number of postpartum complications	ASHA Facilitator, ASHA Coordinator

Desired Behaviour-Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
New-Born/Child Care									
Newborns weighing More than 2.5 kg	Woman, MIL Community Health Workers	Anaemic mother Weighing not preferred culturally All children are not weighed Importance of weighing and its link to health not well understood	To increase knowledge and intention to weigh baby To approve of better and balanced diet during pregnancy with IFA	IPC Advocacy Social Mobilization	Video on growth of child and its relation to weight SOPs for Health Staff	Functional Instruments	Positive Deviants could be used	Increase in proportion of children weighing more than 2.5 Kg Increase in proportion of mothers who received need-based counselling on weighing and know whether the child was under weight	
Newborns visited within 24hrs of home delivery	Woman, MIL Community Health Workers	Women who delivers doesn't meet outsiders Health workers do not negotiate and avoid checking the symptoms	To increase proportion of people who appreciate care after delivery	IPC Social mobilization	Visual Aid (Flip Book) Checklist on symptoms	Orientation of the workers on their knowledge of symptoms on regular basis	Handholding by Medical staff if ASHA/AWW is making the home visit	Increase in proportion of woman visited by health staff with 24 hours	ASHA Facilitator ASHA Coordinator

Desired Behaviour - Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Reproductive									
Post-partum sterilization	Woman, Spouse MIL	Do not appreciate importance of sterilization just after delivery Have fear of the two things coming together Newly delivered Child's well-being is a concern	To increase acceptance of post partum sterilization	IPC	Flip Book SOPs	Quality of Services	Health Staff to counsel after delivery	Increase in proportion of woman who opted for Post partum Sterilization	ASHA Facilitator ASHA Coordinator
Male sterilization	Man	Stigma attached Apprehension about sexual life Do not think it is man's job	To accept sterilization is couple's responsibility To appreciate that sterilization for males is easier and pain free compared to females To realize and accept male sterilization doesn't hinder sexual life	Mid media Print Media Advocacy	Street Play Flash cards Role Models	Quality services	Counselling post sterilization	Increase in proportion of male sterilization	ASHA facilitator ASHA Coordinator

Block lock Level SBBC Plan (Raniwara)									
Desired Behaviour - Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Pregnancy									
ANC Registration with in 1st Trimester	Woman and MIL	Taboo to disclose pregnancy	To sensitize on early registration	IPC	Communication Aids	Supply of Nichay kit	Confidentiality of information to be ensured	HH hold visits and women/ families counselled	ASHA Facilitator
Preg. women received 3 ANC check-ups	Woman, Spouse, MIL, Community	Pregnancy considered a routine activity Son preference	To approve that pregnancy needs extra care and close monitoring	IPC Advocacy Mass Media	Mobile Device (Any visual aid for effectiveness)	All functional instruments	Regularity of MCHN Day, Availability of ANM All test to be conducted and need-based counselling	Women received 3+ ANC	ASHA Facilitator

Desired Behaviour - Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Delivery									
SBA attended home deliveries Institutional deliveries	Woman, MIL, Spouse	Low pregnancy preparedness Unavailability of transport Prefer home deliveries	To increase realization of importance of birth preparedness To facilitate institutional deliveries To increase approval of importance of institutional delivery/delivery by skilled health person	IPC Social Mobilization		Availability of Skilled Birth Attendant 24* 7 health facilities		Women delivered by SBA Institutional Deliveries	ASHA Facilitator
Women Stay 48 hrs and more after delivery in public institutions	Women, MIL Nursing Staff	Dangers of post-partum not known No play for the attendants to stay Staff not strict on adhering to the norm	To provide knowledge on dangers	IPC Social Mobilization Advocacy	Flash cards Video Mobile device (message/clipping) SOPs for Health Staff	Adequate Infrastructure to bear patient load	Provision of Stay arrangement of attendants	Increase in the proportion of women who stayed for 48 hours or more after delivery Decrease in number of postpartum complications	ASHA Facilitator, ASHA Coordinator

Desired Behaviour – Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
New-Born/Child Care									
Newborns weighing More than 2.5 kg	Woman, MIL Community Health Workers	Anaemic mother Weighing not preferred culturally All children are not weighed Importance of weighing and its link to health not well understood	To increase knowledge and intention to weigh baby To approve of better and balanced diet during pregnancy with IFA	IPC Advocacy Social Mobilization	Video on growth of child and its relation to weight SOPs for Health Staff	Functional Instruments	Positive Deviants could be used	Increase in proportion of children weighing more than 2.5 Kg Increase in proportion of mothers who received need-based counselling on weighing and know whether the child was under weight	
% of Infants immunized by Measles	Mothers MIL Community	Importance of immunization not appreciated Discomfort to the child is avoided Services not provided every	To increase proportion of people who realize importance of immunization over discomfort	IPC Mass media Social mobilization	Videos Visual Aids	Due list to be prepared Systematic procedure to identify children so that neither vaccine goes waste nor care	Vaccines Conduction of MCHN Day Mobile Services in case of non-availability of staff	Increase in proportion of children immunized	ASHA Facilitator ASHA Coordinator

		time-depended on no of children available Due list not prepared for correct identification				givers have to wait			
Desired Behaviour - Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Reproductive									
Post-partum sterilization	Woman, Spouse MIL	Do not appreciate importance of sterilization just after delivery Have fear of the two things coming together Newly delivered Child's well-being is a concern	To increase acceptance of post partum sterilization	IPC	Flip Book SOPs	Quality of Services	Health Staff to counsel after delivery	Increase in proportion of woman who opted for Post partum Sterilization	ASHA Facilitator ASHA Coordinator

Male sterilization	Man	Stigma attached Apprehension about sexual life Do not think it is man's job	To accept sterilization is couple's responsibility To appreciate that sterilization for males is easier and pain free compared to females To realize and accept male sterilization doesn't hinder sexual life	Mid media Print Media Advocacy	Street Play Flash cards Role Models	Quality services	Counselling post sterilization	Increase in proportion of male sterilization	ASHA facilitator ASHA Coordinator
IUD insertions	Woman Spouse	Myths about use of IUCD Fear of side effects Fear of hindrance in sexual life Methods with medical staff intervention considered a hassle as dependency for insertion and removal	To accept IUCD as a pain free method To appreciate that insertion and removal is hassle free	IPC Mid-Media	Video to remove the myths and its functioning Role Models Street play	Quality services by skilled staff	Follow-up using a checklist to resolve any side-effects to the satisfaction of the woman/couple	Increase in proposition of woman with IUD insertions	ASHA Facilitator ASHA Coordinator

Block lock Level SBBC Plan (Sanchore)									
Desired Behaviour - Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Pregnancy									
ANC Registration with in 1st Trimester	Woman and MIL	Taboo to disclose pregnancy	To sensitize on early registration	IPC	Communication Aids	Supply of Nichay kit	Confidentiality of information to be ensured	HH hold visits and women/ families counselled	ASHA Facilitator
Preg. women received 3 ANC check-ups	Woman, Spouse, MIL, Community	Pregnancy considered a routine activity Son preference	To approve that pregnancy needs extra care and close monitoring	IPC Advocacy Mass Media	Mobile Device (Any visual aid for effectiveness)	All functional instruments	Regularity of MCHN Day, Availability of ANM All test to be conducted and need-based counselling	Women received 3+ ANC	ASHA Facilitator

Desired Behaviour-Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Delivery									
SBA attended home deliveries	Woman, MIL, Spouse	Low pregnancy preparedness Unavailability of transport Prefer home deliveries	To increase realization of importance of birth preparedness To facilitate institutional deliveries To increase approval of importance of institutional delivery/delivery by skilled health person	IPC Social Mobilization		Availability of Skilled Birth Attendant 24* 7 health facilities		Women delivered by SBA Institutional Deliveries	ASHA Facilitator
Women Stay 48 hrs and more after delivery in public institutions	Women, MIL Nursing Staff	Dangers of post-partum not known No play for the attendants to stay Staff not strict on adhering to the norm	To provide knowledge on dangers	IPC Social Mobilization Advocacy	Flash cards Video Mobile device (message/clipping) SOPs for Health Staff	Adequate Infrastructure to bear patient load	Provision of Stay arrangement of attendants	Increase in the proportion of women who stayed for 48 hours or more after delivery Decrease in number of postpartum complications	ASHA Facilitator, ASHA Coordinator

Desired Behaviour - Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
New-Born/Child Care									
Newborns weighing More than 2.5 kg	Woman, MIL Community Health Workers	Anaemic mother Weighing not preferred culturally All children are not weighed Importance of weighing and its link to health not well understood	To increase knowledge and intention to weigh baby To approve of better and balanced diet during pregnancy with IFA	IPC Advocacy Social Mobilization	Video on growth of child and its relation to weight SOPs for Health Staff	Functional Instruments	Positive Deviants could be used	Increase in proportion of children weighing more than 2.5 Kg Increase in proportion of mothers who received need-based counselling on weighing and know whether the child was under weight	
% of Infants immunized by Measles	Mothers MIL Community	Importance of immunization not appreciated Discomfort to the child is avoided Services not provided every	To increase proportion of people who realize importance of immunization over discomfort	IPC Mass media Social mobilization	Videos Visual Aids	Due list to be prepared Systematic procedure to identify children so that neither vaccine goes waste nor care	Vaccines Conduction of MCHN Day Mobile Services in case of non-availability of staff	Increase in proportion of children immunized	ASHA Facilitator ASHA Coordinator

		time-depended on no of children available Due list not prepared for correct identification				givers have to wait			
Desired Behaviour	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Reproductive									
Post-partum sterilization	Woman, Spouse MIL	Do not appreciate importance of sterilization just after delivery Have fear of the two things coming together Newly delivered Child's well-being is a concern	To increase acceptance of post partum sterilization	IPC	Flip Book SOPs	Quality of Services	Health Staff to counsel after delivery	Increase in proportion of woman who opted for Post partum Sterilization	ASHA Facilitator ASHA Coordinator

Male sterilization	Man	Stigma attached Apprehension about sexual life Do not think it is man's job	To accept sterilization is couple's responsibility To appreciate that sterilization for males is easier and pain free compared to females To realize and accept male sterilization doesn't hinder sexual life	Mid media Print Media Advocacy	Street Play Flash cards Role Models	Quality services	Counselling post sterilization	Increase in proportion of male sterilization	ASHA facilitator ASHA Coordinator

Block lock Level SBBC Plan (Sayla)									
Desired Behaviour - Prioritized	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Pregnancy									
ANC Registration with in 1st Trimester	Woman and MIL	Taboo to disclose pregnancy	To sensitize on early registration	IPC	Communication Aids	Supply of Nichay kit	Confidentiality of information to be ensured	HH hold visits and women/ families counselled	ASHA Facilitator
Preg. women received 3 ANC check-ups	Woman, Spouse, MIL, Community	Pregnancy considered a routine activity Son preference	To approve that pregnancy needs extra care and close monitoring	IPC Advocacy Mass Media	Mobile Device (Any visual aid for effectiveness)	All functional instruments	Regularity of MCHN Day, Availability of ANM All test to be conducted and need-based counselling	Women received 3+ ANC	ASHA Facilitator

Desired Behaviour - Prioritized	Audiences	Barriers	Communication Objective	Channels	Communication Aid	Institutional Support	Other support	Deliverables	M& E
Delivery									
SBA attended home deliveries Institutional deliveries	Woman, MIL, Spouse	Low pregnancy preparedness Unavailability of transport Prefer home deliveries	To increase realization of importance of birth preparedness To facilitate institutional deliveries To increase approval of importance of institutional delivery/delivery by skilled health person	IPC Social Mobilization		Availability of Skilled Birth Attendant 24* 7 health facilities		Women delivered by SBA Institutional Deliveries	ASHA Facilitator

Women Stay 48 hrs and more after delivery in public institutions	Women, MIL Nursing Staff	Dangers of post-partum not known No play for the attendants to stay Staff not strict on adhering to the norm	To provide knowledge on dangers	IPC Social Mobilization Advocacy	Flash cards Video Mobile device (message/clipping) SOPs for Health Staff	Adequate Infrastructure to bear patient load	Provision of Stay arrangement of attendants	Increase in the proportion of women who stayed for 48 hours or more after delivery Decrease in number of postpartum complications	ASHA Facilitator, ASHA Coordinator
Desired Behaviour	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
New-Born/Child Care									
% of Infants immunized by Measles	Mothers MIL Community	Importance of immunization not appreciated Discomfort to the child is avoided Services not provided every time- depended on no of children	To increase proportion of people who realize importance of immunization over discomfort	IPC Mass media Social mobilization	Videos Visual Aids	Due list to be prepared Systematic procedure to identify children so that neither vaccine goes waste nor care givers have to wait	Vaccines Conduction of MCHN Day Mobile Services in case of non-availability of staff	Increase in proportion of children immunized	ASHA Facilitator ASHA Coordinator

		available Due list not prepared for correct identification							
Desired Behaviour	**Audiences**	**Barriers**	**Communication Objective**	**Channels**	**Communication Aid**	**Institutional Support**	**Other support**	**Deliverables**	**M& E**
Reproductive									
Post-partum sterilization	Woman, Spouse MIL	Do not appreciate importance of sterilization just after delivery Have fear of the two things coming together Newly delivered Child's well-being is a concern	To increase acceptance of post partum sterilization	IPC	Flip Book SOPs	Quality of Services	Health Staff to counsel after delivery	Increase in proportion of woman who opted for Post partum Sterilization	ASHA Facilitator ASHA Coordinator
Male sterilization	Man	Stigma attached Apprehension	To accept sterilization is couple's	Mid media Print Media	Street Play Flash cards	Quality services	Counselling post sterilization	Increase in proportion of male	ASHA facilitator ASHA Coordinator

		about sexual life Do not think it is man's job	responsibility To appreciate that sterilization for males is easier and pain free compared to females To realize and accept male sterilization doesn't hinder sexual life	Advocacy	Role Models			sterilization	

Annexure 6.6

Sample of some Communication Material in Use

Posters

Talking Points/Counseling Aids	
	Size: 21cmx12.5cm Text: Ghar-Ghar jayen aur har ma ko samjhaye shishu ko stanpan sahi sthiti mai karaye
	Size: 21cmx12.5cm Text: Navjaat shishu ko thand se bachaye, topi kapde aache se odhaye, maa ke pass hi sulaye.
	Size: 21cmx12.5cm Text: Shishu ko 6 mah tak stanpan hi karvaye, uper se pani bhi nahi pilaye.

Audio Clippings	
http://nrhmrajasthan.nic.in/Audio%20Clipping/Chota%20Pariwar.wma	Family Planning
http://nrhmrajasthan.nic.in/Audio%20Clipping/Safe%20delivery.wma	Safe Delivery
http://nrhmrajasthan.nic.in/Audio%20Clipping/Breastfeeding.wma	Breastfeeding
Video Clipping	

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http://nrhmrajasthan.nic.in/Audio%20Clipping/Chota%20Pariwar.wma	**Family Planning**
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http://nrhmrajasthan.nic.in/Audio%20Clipping/Breastfeeding.wma	**Breastfeeding**
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