

IMPROVING HEALTHY BEHAVIORS PROGRAM IN INDIA

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FHI Development 360 LLC (FHI 360)
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Acronyms and Abbreviations

AAP	Annual Action Plan
ACSM	advocacy, communication, and social mobilization
AIDS	Acquired Immunodeficiency Syndrome
AMC	Annual Maintenance Contract
AMP	Award Monitoring Plan
ANC	antenatal care
ANM	auxiliary nurse midwife
ASHA	accredited social health activist
AWC	Anganwadi Center
AWP	Annual Work Plan
AWW	anganwadi worker
BCC	behavior change communication
CO	Contracting Officer
COR	Contracting Officer's Representative
COTR	Contracting Officer's Technical Representative
CTD	Central Tuberculosis Division
DDG	Deputy Director General
DLHS	District-Level Household and Facility Survey
DOTS	Directly Observed Treatment, Short-Course
DOWCD	Department of Women and Child Development
EAG	Empowered Action Group
FP	family planning
FGD	focus group discussion
FHI 360	FHI Development 360 LLC
FSW	female sex worker
GOI	Government of India
HIV	human immunodeficiency syndrome
ICDS	Integrated Child Development Services
ICT	information communication technologies
ICTC	Integrated Counseling and Testing Center
IDI	in-depth interview
IDU	intravenous drug user
IEC	information, education, and communication
IFA	iron/folic acid
IHBP	Improving Healthy Behaviors Program in India
IMACS	ICRA Management Consulting Services Limited
IPC	interpersonal communication
IR	Intermediate Result
IT	information technology
ITBP	India TB Program
IUCD	intrauterine contraceptive device
JHUCCP	Johns Hopkins University Center for Communication Programs
JS	Joint Secretary
JSSK	Janani-Shishu Suraksha Karyakram
M&E	monitoring and evaluation
MCH	maternal and child health
MD	Medical Director

MH	maternal health
MOHFW	Ministry of Health and Family Welfare
MOIB	Ministry of Information and Broadcasting
MOU	Memorandum of Understanding
MOWCD	Ministry of Women and Child Development
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NGO	nongovernmental organization
NHCRSC	National HIV/AIDS Communication Resource and Support Centre
NIC	National Informatics Center
NIHFW	National Institute of Health and Family Welfare
NIPCCD	National Institute of Public Cooperation and Child Development
NRHM	National Rural Health Mission
NRP	Nutrition Resource Platform
OCP	oral contraceptive pill
ONA	organizational needs assessment
PCI	Project Concern International
PIP	Project Implementation Plan
PLHIV	people living with HIV
POA	Plan of Action
PopCouncil	Population Council
PRACHAR	Promoting Change in Reproductive Behavior Project
PSI	Population Services International
RCH	Reproductive and Child Health
RCH-II	Reproductive and Child Health II program
RCP	Radio Communication Project
RFP	request for proposals
RH	reproductive health
RNTCP	Revised National TB Control Programme
SACS	state AIDS control society
SBCC	social and behavior change communication
SGD	simulated group discussion
SOW	scope of work
STI	sexually transmitted infection
TA	technical assistance
TB	tuberculosis
TOR	terms of reference
TVC	television commercial
UP	Uttar Pradesh
UPSACS	Uttar Pradesh State AIDS Control Society
USAID	United States Agency for International Development

I. Introduction

This report documents activities implemented, results accomplished, and challenges and lessons learned from the second year implementation of the United States Agency for International Development (USAID)-funded task order (TO) for the “Behavior Change Communication – Improving Healthy Behaviors Program in India” (IHBP) from October 1, 2011 to September 30, 2012. On October 25, 2010, USAID/India awarded a TO to AED to implement IHBP. With acquisition of AED assets by FHI, the task order was novated to FHI Development LLC (FHI 360) on June 30, 2011, in a task order modification signed by the USAID Contracting Officer (CO) on September 14, 2011.

The goal of IHBP is to improve adoption of positive healthy behaviors through institutional and human resource capacity building of national, state, and district-level institutions. As per the TO, the geographic focus at the state level was to be Uttar Pradesh (UP), where IHBP would cover 10 districts. At the end of Year 1 of IHBP implementation, USAID, responding to a request from the Ministry of Health and Family Welfare (MOHFW), indicated that UP would not be the focus state for IHBP. USAID further instructed the project to focus on national-level activities until a new focus state was named. As of the end of Year 2, USAID had not yet identified a focus state, although it agreed that IHBP could provide grants for specific activities in blocks of two districts of UP and also work with the UP State AIDS Control Society (UPSACS) in Year 3.

IHBP focuses on four program areas—HIV/AIDS, family planning/reproductive health (FP/RH), TB, and maternal and child health (MCH)—and works with the following national level government agencies, and affiliated training institutions: MOHFW, the National AIDS Control Organization (NACO), and the Ministry of Women and Child Development (MOWCD). FHI 360’s strategy is guided by the Social and Behavior Change Communication (SBCC) framework, developed through the USAID-funded C-Change project, which recognizes that individual health behaviors are influenced not only by individual and family factors, but also by larger social, environmental, and economic factors. Considering this, it is important to address these larger issues.

The TO is for a base period of three years with two 1-year options. The period of performance for the base period is October 1, 2010 to September 30, 2013. The first option year is October 1, 2013 to September 30, 2014, and the second option year is October 1, 2014 to September 30, 2015. The total estimated cost plus fixed fee for the 5-year period is \$46,674,263. USAID/India obligated \$11.5 million in 2010 for project activity implementation and no further obligations have been made since.

FHI 360 signed subcontracts with two implementing partners: Population Council (PopCouncil) and Population Services International (PSI). PopCouncil is supporting operations research and monitoring and evaluation (M&E), while PSI is supporting mid-media, interpersonal communication (IPC), and partnerships with private sector health networks. On July 25, 2011, USAID granted approval for FHI 360 to enter into a subcontract with Project Concern International (PCI) to provide support to community mobilization activities. However, no subcontract has been signed between FHI 360 and PCI.

II. Project Background

1. Behavior Change Communication (BCC) in the Government Health System

IHBP is USAID's response to strengthen BCC capacity within the government health system. This response is based on gaps identified by previous government and donor-led reviews of BCC capacity at MOHFW, e.g., the mid-term review of the Reproductive and Child Health II program (RCH-II), 2008–2009, and the UNICEF Review, 2008. Key gaps highlighted were:

- Limited capacity within the system for management of evidence-based BCC
- Stand-alone information, education, and communication (IEC)/BCC activities with minimal linkage to service delivery
- Weak counseling at facilities

These gaps resulted in, among other things, the absence of an evidence-based integrated BCC strategy, a low utilization of funds, a focus on mass media and print materials, and the absence of pretesting of materials.

2. About IHBP

2.1. IHBP Intermediate Results and Approaches

USAID's Assistance Objective in India is to strengthen health systems to address the health needs of vulnerable populations, thereby supporting India's efforts to achieve the Millennium Development Goals (MDGs). IHBP contributes to this objective, specifically, to Intermediate Result (IR) 3, Increased Healthy Behaviors, through four key results.

Result 1: Institutions and capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels.

IHBP supports an evidence-based approach for designing communication strategies and plans. For Year 2, this objective was focused on MOHFW and MOWCD at the national level. IHBP conducted organizational needs assessments (ONAs) of IEC/BCC at MOHFW and MOWCD, developed plans of action (POAs), developed and pilot tested a training module for frontline workers, and supported BCC resource centers.

Result 2: Accurate and appropriate knowledge/attitudes increased in individuals, families, communities, and providers at district, state, and national levels.

IHBP, in partnership with government organizations, strategically targets families and individuals to improve health knowledge, attitudes, and behaviors. In Year 2, IHBP supported development of two evidence-based BCC campaigns by MOHFW: one for FP and one for MH. To further support government BCC plans, the project will manage a grants program for local nongovernmental organizations (NGOs) to implement innovative communication activities at the village level in pilot districts in Year 3.

Result 3: Community platforms, organizations, and key individuals (influencers) support improved health behaviors.

To create a supportive community and social environment for healthy behaviors, the project will engage key influencers in the community. During Year 2, IHBP provided technical assistance (TA) at the national level for messages and materials to be used through government and NGO channels. For Year 3, this will be achieved through the grants program in a few select districts to strengthen roll-out of mid-media and IPC activities in line with MOHFW's national FP and MH BCC campaigns.

Result 4: Vulnerable communities empowered to seek health services and products.

The project aims to address stigma and discrimination (S&D) issues that prevent vulnerable individuals and families, especially marginal groups and women, from seeking health care for HIV/AIDS and TB. In Year 3, IHBP will support in-depth studies that explore root causes of S&D, and enhance skills of health providers and community-based workers to address S&D.

A strong M&E system will gather information on the progress of IHBP activities and feed that information back to the project and partner government agencies.

2.2. IHBP Guiding Principles

IHBP, in adhering to USAID/India's funding policy, views its resources as providing catalytic support, sources of innovation, and models and pilots for more effective and efficient use of the substantial funds that are available from the GOI. Rather than invest in direct implementation, the project supports quality TA, cooperation, and partnership, e.g., development of prototype communication materials with mass production and media placements borne by government, development of training modules and training of trainers with cascade trainings undertaken by government, and evaluation studies.

2.3. Leveraging

Leveraging resources is an important component of the project. IHBP has identified a number of innovative public-private partnerships (PPPs) and leveraging ideas that were discussed with business sector leaders and organizations, including the Federation of Indian Chambers of Commerce and Industry and the Confederation of Indian Industry. In Year 3, the project will work with the commercial sector using two general approaches: working with corporate social responsibility (CSR) programs, and developing sustainable "win-win" situations wherein a company can expand the commercial availability of its relevant health products or services that are a part of its core business. IHBP is leveraging the use of GOI funding to implement evidence-based campaigns and capacity building programs at national and state levels.

2.4. IHBP Implementation Strategy

IHBP's implementation strategy is as follows.

- IHBP staff provides TA to government counterparts at the national level on various aspects of BCC programming through a mentoring, learning-by-doing approach.
- IHBP staff supports development of national level integrated BCC campaigns, including prototype communication materials, and capacity building activities
- IHBP seconds long-term BCC consultants with a variety of BCC skill sets to work closely with and provide TA to national level government counterparts.
- IHBP works with government training counterparts, such as the National Institute of Health and Family Welfare (NIHFW), to include evidence-based BCC in training modules, and training programs.
- IHBP, pending agreement of MOHFW and USAID, proposes to strengthen the capacity of a nodal organization¹ to be selected based on the results of the recently-completed scoping study, which will provide TA on BCC to government and take over IHBP TA when the project ends.

¹ Nodal organizations are not-for-profit and for-profit agencies that IHBP will identify to groom as a TA agencies to MOHFW, NACO, MOWCD, and their counterparts in the state for SBCC.

- IHBP will support pilot activities on community mobilization and IPC at the block level to be implemented by NGO grantees that will coordinate with government to promote GOI/IHBP campaign approaches.
- IHBP will conduct monitoring and evaluation activities.

III. Developments Affecting IHBP Task Order Terms and Conditions in Year 2

1. Historical Overview: AED Suspension, Acquisition by FHI, and Novation of Task Order to FHI Development 360 LLC – December 2010

In December 2010, due to AED's suspension by USAID/Washington, the USAID/India CO instructed IHBP to delay major actions, e.g., signing of leases, staff recruitment, major procurements, and work plan activity implementation, including meetings with government, USAID partners, and other donors. This instruction delayed full project start-up. It was rescinded in late March 2011, after which IHBP resumed major activities.

On July 1, 2011, FHI finalized acquisition of AED's assets. In accordance with the novation dated June 30, 2011, the IHBP task order contractor name was changed from AED to FHI Development 360 LLC (FHI 360) in a modification signed by the USAID CO on September 14, 2011. The contract awardee is now FHI 360.

2. No Identified Focus State for IHBP

On August 11, 2011, USAID informed IHBP that MOHFW requested USAID to consider discontinuing assistance to health programs in UP and move to another state. In mid-August 2011, USAID instructed IHBP to slow down implementation of UP activities, especially those concerning the Department of Health and Family Welfare, and focus its efforts, instead, on national-level activities. USAID added that until the issue was resolved, it would not act on any IHBP requests for UP, including those already submitted to the Contracting Officer's Representative (COR). IHBP, thus, postponed major actions for UP like recruitment, signing of the UP office lease, and implementation of major activities.

On February 28, 2012, in a meeting held between MOFHW (represented by Additional Secretary Keshan Desiraju), and USAID (represented by Ms. Kerry Pelzman, Health Office Director), Rajasthan was identified as the focus state for USAID and IHBP support. Considering this, USAID informed IHBP that it could proceed with a situation analysis of Rajasthan but added that the project could not pursue meetings with Rajasthan officials and stakeholders nor initiate state activities until IHBP received formal notice of this decision.

In April 2012, USAID informed IHBP that Rajasthan was not to be the focus state for IHBP/USAID and that IHBP needed to continue its national focus pending a final decision on a focus state. During work plan discussions for the period July 2012–September 2013 held in June, IHBP was advised to plan for pilot activities through the grants program in two districts of UP to support the national FP and MH campaigns. By the end of September 2012, no focus state had been named by USAID for IHBP.

3. No Formal Approval of Year 2 Annual Work Plan

Due to AED's suspension, USAID delayed approval of IHBP's Year 1 Annual Work Plan (AWP) for the period October 2010–September 2011 which was submitted on November 29, 2010. After a series of revisions to incorporate USAID comments, USAID formally approved this Year 1 AWP and IHBP's Award Monitoring Plan (AMP) on August 8, 2011, and the Branding and Marking Plan on September 7, 2011.

During the entire Year 2 period, IHBP operated without a formally approved AWP. IHBP submitted its Year 2 AWP and updated AMP to USAID on September 19, 2011. There are ongoing negotiations between USAID and the GOI on a focus state for USAID and IHBP under the Health Partnership Program Agreement (HPPA) and, thus, the submitted work plan, which has a national-level focus, will be further revised and submitted as an interim measure until a state is named.

IV. IHBP – Accomplishments in Year 2 (October 2011–September 2012)

In Year 2, in the absence of formal USAID approval of its AWP and updated AMP, IHBP carried out national-level activities based on discrete requests by government agencies that were sanctioned by USAID on a per-activity basis. IHBP also continued national-level activities that were initiated in Year 1. In early 2012, USAID and IHBP agreed to propose year-long Plans of Action (POAs) to national-level agencies that would form the basis for IHBP TA. For 2012, IHBP pursued activities based on these draft POAs submitted to MOHFW for the IEC, FP, and MH Divisions in May 2012; to MOHFW-Central Tuberculosis Division (CTD) on March 28, 2012; and to NACO on February 14, 2012. However, despite IHBP requests to the particular agencies, these POAs have not been approved in writing. The project also continued activities based on agreements with MOWCD for TA.

The table on the following pages provides a snapshot of IHBP's Year 2 accomplishments.

Type of Indicator	Indicator	FY12 Target	Achievements FY12	Target Rationale	How Target Was Established	Significance of Achieving Target	Relevance to the Program	Source of Data
Outcomes	Nodal institutions established with USG assistance for providing institutional strengthening support to Government agencies	2	0 – Work with nodal organization was not approved during the reporting period FY12. Initial scoping study undertaken.	IHBP has committed to identify at least one organization each at national and at state level to provide TA to Government agencies, and to strengthen their capacities during this year and the following project years until the project activities completion date.	The target is in response to contractual requirements and assuming that achieving this target is viable in the indicated period.	The program will be able to create environment and local capacity for sustainable TA in BCC and social mobilization for national and state programs.	Local organizations with enhanced capacity in BCC and social mobilization will be able to continue high quality TA to national and state governments.	Project records
	Evidence-based campaigns developed by government agencies with direct support from IHBP TA	3	2 full campaigns (on FP /RH and MH) plus targeted input to MOHFW for a safe mother hood campaign and NACO for a internet campaign.	As one of IHBP's objectives is to enhance KABP through Government BCC programs, project's assistance in evidence based campaigns will indicate the effectiveness of IHBP's capacity building approach with the Government.	IHBP will be assisting Government agencies/ divisions working in maternal health, child health, family planning, RCH, tuberculosis and HIV/AIDS. It is anticipated that IHBP will be involved in leading TA for at least three of the above six potential topics.	The project will be able to assist in improving reach, effectiveness and efficacy of government's health campaigns.	Ensure that evidence-based planning is applied in different content areas, thus meeting the program's major objectives regarding institutional development at the national and state levels.	Government and project documents
	% increase in utilization of budget by targeted government agency/ health program for mid-media and IPC	5%	Budget for mid-media and IPC is applicable for states. As IHBP did not have any assigned state, therefore, this activity could not be carried out.	Government's primary focus has been on mass media, with limited resources (HR and financial) for mid-media and IPC. IHBP will provide TA in enhancing effective utilization of available resources for mid-media and IPC. The 5% proposed increase is only keeping in mind the national government. State operations into consideration as the status of the State for project implementation is in abeyance, till further decision from USAID.	Anecdotal evidence from discussions with MOHFW, IEC Division staff informed the project that the mid-media and IPC spending was very small proportion of last year's budget. Though there is specific amount shared with the project, 2011-12 allocation to mid-media in the national IEC budget is Rs. 280 million.	Government capacity enhanced to widen the scope of their IEC/BCC programs, including planning, implementation and monitoring of mid-media and IPC activities.	Begin to reflect a shift in the use of channels used in communication strategies.	Government plan and budget documents (Program Implementation Plans)

Type of Indicator	Indicator	FY12 Target	Achievements FY12	Target Rationale	How Target Was Established	Significance of Achieving Target	Relevance to the Program	Source of Data
Outputs	Number of information gathering or research activities conducted by USG assistance	FY12: 5	6 – One ONA for IEC division of MOHFW, one ONA for MOWCD, one desk review for research on urban TB, one literature review for FP campaign on good BCC practices, one literature review for MH campaign on good BCC practices and one literature review HIV campaign on good BCC practices.	IHBP will be assisting relevant ministries and Government agencies at national and state level in development, implementation, monitoring and evaluation of evidence based BCC strategies. The indicator supports IHBP's TA initiatives in this area of effort.	In FY12, the calculation includes the following reports: Organizational needs assessment, M&E assessment, training systems reviews, communication needs assessment (literature review as well as qualitative studies), etc.. In addition, the baseline for the project will address information gaps. In FY12, IHBP will also initiate state level operations research and qualitative studies in family planning and MCH, reports of which will be available in FY13.	Enriching the pool of available information for institutional strengthening in BCC and also in KABP, to inform project interventions and facilitate evidence based decision making at national and state levels.	Rely on evidence to support the program, thus setting the example for TA recipients of how to proceed in the future.	Project records
	Number of health care workers who successfully completed an in-service training program within the reporting period	FY 12: 60	0 – IHBP was not approved to work at district level during FY12. Training was conducted for 58 ANM's on BCC, which was cross-cutting to project health areas and is reported under child health and nutrition below.	Actual count of training participants based on training events to be implemented at national and state level trained on BCC for HIV/AIDS prevention and control.	FY 12: Training of frontline health workers on BCC for HIV/AIDS prevention and control including training of trainers and some field workers (3 batches) = 60	Enhanced capacity of national, state and district IEC personnel to plan, implement and monitor BCC activities on HIV/AIDS.	Develop necessary skills to get the planned messages delivered on HIV/AIDS to intended audience with a reliance on mid-media and interpersonal communication, thus meeting the project's mandate.	Project and government training records
	Number of local organizations provided with TA for HIV-related institutional capacity building	FY12: 4	2 – NACO and UPSACS. IHBP was not working at district level as planned in FY12 workplan. Only 2 organizations were assigned by USAID and GOI for HIV-related institutional capacity building.	This is an HIV-specific indicator. This year, till we get districts, our TA will be at national and state levels.	For FY12, the count includes NACO, SACs, and two nodal organizations. We assumed that USAID will inform us of the state and the districts before end of 2012.	Local organizations will be able to better plan, implement, monitor and evaluate BCC and social mobilizations interventions.	Meet the project's mandate.	Project records

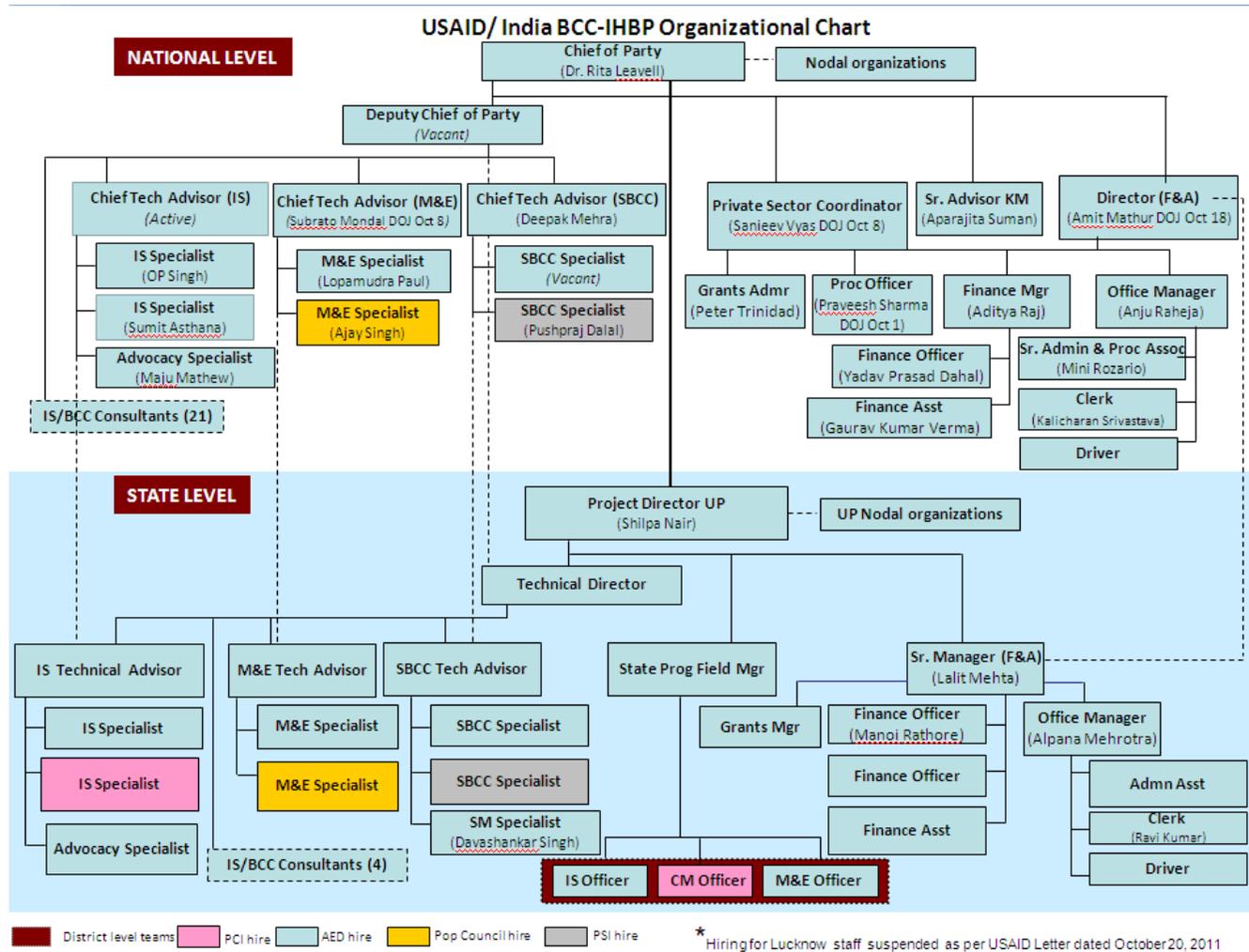
Type of Indicator	Indicator	FY12 Target	Achievements FY12	Target Rationale	How Target Was Established	Significance of Achieving Target	Relevance to the Program	Source of Data
Outputs	Number of individuals trained in HIV-related stigma and discrimination reduction	FY12: 400	0 – The target was calculated assuming district level intervention. IHBP did not have any district during this reporting period.	Training will get started in 10 districts.	Part of FY12 will be devoted to establishing state and district level operations. Staff trained will include IHBP's own staff plus national, state and district level officials, trainers and NGO staff appointed through the Grant Program that IHBP will implement. 1. State: 2 training x 20 = 40 people 2. Districts: 10 districts x 16 NGO staff = 160 people 10 districts x 20 key stakeholders = 200 people.	Increased number of health workers sensitized, thus contributing to positive action in stigma and discrimination reduction. Vulnerable communities will have improved access to healthcare services.	Provide skills to address stigma and discrimination, initiate a change in institutional culture and social norms associated with them.	Project records
	Number of participants trained in the components of the WHO Stop TB strategy with USG funding	FY12: 300	0 – Workplan not approved for 2012; IHBP has shifted this activity to FY13; see targets for FY13).	FY12: IHBP will begin training at national, state, and district levels.	FY12: 1 national workshop x 20 people = 20 1 state workshop x 20 people = 20 10 dist. training (gov't) x 14 people = 140 10 dist. training (IHBP+NGO) x 12 people = 120 FY13: 50 health staff in each one of 10 districts (50 x 10= 500)	Increased number of health workers trained in ACSM activities, which will contribute to improved planning and implementation of mid-media and IPC activities for TB.	Develop necessary skills to get the planned messages delivered to intended audience with a reliance on mid-media and interpersonal communication, thus meeting the project's mandate.	Project and government training records
	Number of people trained in child health and nutrition through USG funding	FY12: 600	58 – IHBP did not work at district or state level in FY12 and therefore frontline worker training could not be implemented. Training was conducted with pilot modules for BCC skills (cross-cutting for FP, HIV, and MCH) for 58 ANMs.	It is assumed that in FY12, IHBP will get 2–3 months to cascade training to sub-district levels. People to be trained will include ASHAs, AWWs, PRIs and members of CBOs and SHGs. Training be focused at state level in Year 2012. The number can only be achieved if IHBP is given a specific state and 10 districts, with at least six months of implementation time.	FY12: 1 national x 10 state trainers = 10 SLTs 1 state x 30 district trainers = 30 DLTs 1 state x 2 orientations x 25 people = 50 people 10 districts x 4 IHBP staff = 40 10 districts x 7 NGO staff = 70 10 districts x 2 trainings x 20 people = 400 people Assumption: this number is for training frontline workers and community leaders in IPC for child health and nutrition only.	Improved communication of child health and nutrition messages by health workers and community leaders.	Develop necessary skills to get the planned messages delivered to intended audience with a reliance on interpersonal communication, thus meeting the project's mandate.	Project and government training records

Type of Indicator	Indicator	FY12 Target	Achievements FY12	Target Rationale	How Target Was Established	Significance of Achieving Target	Relevance to the Program	Source of Data
Outputs	% of audience who recall hearing or seeing a specific USG-supported FP/RH message	FY12: 40%	0 – This activity will be taken up after the MOHFW rolls out the FP campaign nationally and in up to 11 states in FY13.	The 40% recall among target group is based on the assumption that MOHFW will air the FP repositioning campaign spots in six EAG states plus two states, 3 times a day for at least 3 consecutive months.	Based TV viewership and radio listenership as per NFHS-3. Considering the 20-29 years age group population of these states, 40% is actually 18.75 million of the total of about 47 million.	Evidence shows that increased exposure to messages has a direct relationship to uptake of behaviors and services.	One of the first steps in behavior change is to make sure that the message delivered is correctly recalled as a result of frequent exposure.	Recall survey among couples within 20–29 year age group

1. Project Management – Finance and Administration

1.1 IHBP Staff Organigram

As of the end of September 2012, the IHBP organogram is as follows:



1.2 Budget Summary for Period from October 25, 2010 to September 30, 2012

Summary for Period from 10/25/10 to 6/30/12	Project Costs for Year 1					TOTAL COSTS				
	Project Costs for Year 1	Project Costs for Quarter Oct - Dec 11	Project Costs for Quarter Jan - Mar 12	Project Costs for Quarter Apr - Jun 12	Project Costs for Quarter Jul - Sept 12	Family Planning	Tuberculosis	MCH	HIV/AIDS	Total Costs*
	Oct 10 - Sept 11									All Program Elements as of 9/30/12
Result 1										
1.1. Salaries & Wages	\$ 309,770	\$ 76,273	\$ 96,699	\$ 115,220	\$ 119,379	\$ 261,772	\$ 101,857	\$ 114,364	\$ 239,349	\$ 717,342
1.2. Fringe Benefits	\$ 46,006	\$ 11,347	\$ 12,436	\$ 13,238	\$ 8,211	\$ 35,583	\$ 11,861	\$ 11,861	\$ 31,934	\$ 91,239
1.3. Consultants	\$ 9,529.65	\$ 7,213	\$ 2,182	\$ 4,098	\$ 16,662	\$ 9,641	\$ 4,721	\$ 10,594	\$ 14,729	\$ 39,685
1.4. Travel, Transportation & Per Diem	\$ 61,994	\$ 16,404	\$ 3,188	\$ 18,845	\$ 22,641	\$ 46,606	\$ 15,771	\$ 19,339	\$ 41,356	\$ 123,072
1.5. Other Direct Costs	\$ 136,091	\$ 45,209	\$ 81,031	\$ 89,119	\$ 109,878	\$ 154,336	\$ 52,361	\$ 115,437	\$ 139,194	\$ 461,329
1.6. Non-Expendable Equipment & Commodities	\$ -	\$ -	\$ 12,828	\$ 351	\$ -	\$ 5,140	\$ 1,713	\$ 1,713	\$ 4,613	\$ 13,179
1.7. Allowances	\$ 39,214	\$ 9,252	\$ 6,114	\$ 6,482	\$ 6,690	\$ 26,423	\$ 8,808	\$ 8,808	\$ 23,713	\$ 67,751
1.8. VAT	\$ 1,460	\$ 841	\$ 4,801	\$ 1,354	\$ 269	\$ 3,400	\$ 1,138	\$ 1,134	\$ 3,053	\$ 8,724
1.9. Subcontractors	\$ 1,418	\$ 1,766	\$ 3,952	\$ 2,817	\$ 5,644	\$ 6,083	\$ 2,028	\$ 2,028	\$ 5,459	\$ 15,597
1.10. Indirect Costs	\$ 221,070	\$ 61,524	\$ 77,967	\$ 95,517	\$ 82,311	\$ 191,363	\$ 70,109	\$ 101,254	\$ 175,663	\$ 538,389
RESULT 1 TOTAL COST	\$ 826,553	\$ 229,828	\$ 301,198	\$ 347,042	\$ 371,684	\$ 740,346	\$ 270,367	\$ 386,531	\$ 679,061	\$ 2,076,305
1.11. RESULT 1 Fixed Fee	\$ 44,307	\$ 15,003	\$ 21,596	\$ 21,130	\$ 22,794	\$ 48,683	\$ 16,228	\$ 16,228	\$ 43,690	\$ 124,829
RESULT 1 TOTAL COST + FIXED FEE	\$ 870,860	\$ 244,831	\$ 322,794	\$ 368,172	\$ 394,478	\$ 789,029	\$ 286,595	\$ 402,759	\$ 722,751	\$ 2,201,134
Result 2										
2.1. Salaries & Wages	\$ 137,676	\$ 33,899	\$ 51,050	\$ 74,806	\$ 68,010	\$ 145,536	\$ 43,684	\$ 58,329	\$ 117,891	\$ 365,441
2.2. Fringe Benefits	\$ 20,447	\$ 5,043	\$ 5,579	\$ 12,194	\$ 6,164	\$ 22,777	\$ 5,272	\$ 5,272	\$ 16,108	\$ 49,428
2.3. Consultants	\$ 4,235.40	\$ 6,663	\$ 11,540	\$ 12,304	\$ -	\$ 13,960	\$ 2,926	\$ 9,428	\$ 8,429	\$ 34,743
2.4. Travel, Transportation & Per Diem	\$ 27,553	\$ 7,291	\$ 1,417	\$ 15,077	\$ 13,292	\$ 25,288	\$ 5,954	\$ 17,112	\$ 16,276	\$ 64,630
2.5. Other Direct Costs	\$ 60,485	\$ 20,093	\$ 51,450	\$ 177,133	\$ 75,639	\$ 173,419	\$ 21,891	\$ 96,236	\$ 93,254	\$ 384,800
2.6. Non-Expendable Equipment & Commodities	\$ -	\$ -	\$ 5,701	\$ 156	\$ -	\$ 2,284	\$ 761	\$ 761	\$ 2,050	\$ 5,857
2.7. Allowances	\$ 17,428	\$ 4,112	\$ 2,717	\$ 2,881	\$ 2,973	\$ 11,743	\$ 3,914	\$ 3,914	\$ 10,539	\$ 30,111
2.8. VAT	\$ 649	\$ 374	\$ 2,134	\$ 655	\$ 141	\$ 1,534	\$ 504	\$ 560	\$ 1,356	\$ 3,953
2.9. Subcontractors	\$ 18,200	\$ (7,333)	\$ 13,831	\$ 9,861	\$ 145,625	\$ 70,272	\$ 23,424	\$ 23,424	\$ 63,064	\$ 180,184
2.10. Indirect Costs	\$ 98,253	\$ 29,157	\$ 48,789	\$ 116,290	\$ 48,156	\$ 143,970	\$ 30,676	\$ 69,742	\$ 96,257	\$ 340,646
RESULT 2 TOTAL COST	\$ 384,926	\$ 99,298	\$ 194,210	\$ 421,357	\$ 360,001	\$ 610,783	\$ 139,006	\$ 284,779	\$ 425,224	\$ 1,459,792
2.11. RESULT 2 Fixed Fee	\$ 19,692	\$ 6,668	\$ 9,598	\$ 25,654	\$ 10,130	\$ 27,980	\$ 9,327	\$ 9,327	\$ 25,110	\$ 71,743
RESULT 2 TOTAL COST + FIXED FEE	\$ 404,618	\$ 105,966	\$ 203,808	\$ 447,011	\$ 370,131	\$ 638,763	\$ 148,333	\$ 294,105	\$ 450,334	\$ 1,531,535

Summary for Period from 10/25/10 to 6/30/12	Project Costs for Year 1					TOTAL COSTS				
	Project Costs for Year 1	Project Costs for Quarter Oct - Dec 11	Project Costs for Quarter Jan - Mar 12	Project Costs for Quarter Apr - Jun 12	Project Costs for Quarter Jul - Sept 12	Family Planning	Tuberculosis	MCH	HIV/AIDS	Total Costs*
	Oct 10 - Sept 11									All Program Elements as of 9/30/12
Result 3										
3.1. Salaries & Wages	\$ 172,094	\$ 33,899	\$ 45,058	\$ 53,156	\$ 63,142	\$ 133,096	\$ 49,002	\$ 64,048	\$ 121,202	\$ 367,349
3.2. Fringe Benefits	\$ 25,559	\$ 5,043	\$ 5,527	\$ 5,884	\$ 4,562	\$ 18,164	\$ 6,055	\$ 6,055	\$ 16,301	\$ 46,575
3.3. Consultants	\$ 5,294.25	\$ 3,206	\$ 970	\$ 187	\$ 15	\$ 3,766	\$ 1,271	\$ 1,255	\$ 3,380	\$ 9,672
3.4. Travel, Transportation & Per Diem	\$ 34,441	\$ 7,291	\$ 1,417	\$ 5,244	\$ 5,588	\$ 21,053	\$ 7,018	\$ 7,018	\$ 18,893	\$ 53,981
3.5. Other Direct Costs	\$ 75,606	\$ 20,093	\$ 36,264	\$ 28,942	\$ 22,466	\$ 69,047	\$ 23,971	\$ 26,970	\$ 63,381	\$ 183,370
3.6. Non-Expendable Equipment & Commodities	\$ -	\$ -	\$ 5,701	\$ 156	\$ -	\$ 2,284	\$ 761	\$ 761	\$ 2,050	\$ 5,857
3.7. Allowances	\$ 21,785	\$ 4,112	\$ 2,717	\$ 2,881	\$ 3,717	\$ 13,733	\$ 4,578	\$ 4,578	\$ 12,324	\$ 35,212
3.8. VAT	\$ 811	\$ 374	\$ 2,134	\$ 600	\$ 145	\$ 1,585	\$ 528	\$ 528	\$ 1,423	\$ 4,064
3.9. Subcontractors	\$ 19,792	\$ (7,261)	\$ 13,831	\$ 9,861	\$ 139,871	\$ 68,677	\$ 22,892	\$ 22,892	\$ 61,633	\$ 176,094
3.10. Indirect Costs	\$ 122,817	\$ 3,295	\$ 36,138	\$ 37,486	\$ 29,093	\$ 84,612	\$ 30,258	\$ 36,862	\$ 77,096	\$ 228,829
RESULT 3 TOTAL COST	\$ 478,200	\$ 70,051	\$ 149,758	\$ 144,397	\$ 268,599	\$ 416,018	\$ 146,335	\$ 170,968	\$ 377,683	\$ 1,111,004
3.11. RESULT 3 Fixed Fee	\$ 24,615	\$ 6,668	\$ 9,598	\$ 8,792	\$ 12,663	\$ 24,311	\$ 8,104	\$ 8,104	\$ 21,817	\$ 62,336
RESULT 3 TOTAL COST + FIXED FEE	\$ 502,815	\$ 76,719	\$ 159,356	\$ 153,188	\$ 281,262	\$ 440,329	\$ 154,438	\$ 179,072	\$ 399,501	\$ 1,173,340
Result 4										
4.1. Salaries & Wages	\$ 68,838	\$ 25,424	\$ 29,988	\$ 36,537	\$ 29,082	\$ 68,504	\$ 26,861	\$ 31,778	\$ 62,727	\$ 189,869
4.2. Fringe Benefits	\$ 10,224	\$ 3,782	\$ 4,145	\$ 4,413	\$ 1,825	\$ 9,512	\$ 3,171	\$ 3,171	\$ 8,536	\$ 24,389
4.3. Consultants	\$ 2,117.70	\$ 2,404	\$ 727	\$ -	\$ -	\$ 2,047	\$ 682	\$ 682	\$ 1,837	\$ 5,249
4.4. Travel, Transportation & Per Diem	\$ 13,776	\$ 5,468	\$ 1,063	\$ 3,925	\$ 3,928	\$ 10,288	\$ 5,211	\$ 3,429	\$ 9,232	\$ 28,160
4.5. Other Direct Costs	\$ 30,242	\$ 15,070	\$ 26,741	\$ 19,146	\$ 9,263	\$ 38,154	\$ 13,415	\$ 14,293	\$ 34,601	\$ 100,462
4.6. Non-Expendable Equipment & Commodities	\$ -	\$ -	\$ 4,276	\$ 117	\$ -	\$ 1,713	\$ 571	\$ 571	\$ 1,538	\$ 4,393
4.7. Allowances	\$ 8,714	\$ 3,084	\$ 2,038	\$ 2,161	\$ 1,487	\$ 6,818	\$ 2,273	\$ 2,273	\$ 6,119	\$ 17,483
4.8. VAT	\$ 325	\$ 280	\$ 1,600	\$ 450	\$ 60	\$ 1,058	\$ 355	\$ 353	\$ 950	\$ 2,716
4.9. Subcontractors	\$ 1,775	\$ 3,484	\$ 7,904	\$ 5,635	\$ 11,287	\$ 11,733	\$ 3,911	\$ 3,911	\$ 10,530	\$ 30,084
4.10. Indirect Costs	\$ 49,127	\$ 45,266	\$ 25,294	\$ 25,631	\$ 12,007	\$ 58,695	\$ 21,947	\$ 23,418	\$ 53,264	\$ 157,324
RESULT 4 TOTAL COST	\$ 185,138	\$ 104,262	\$ 103,776	\$ 98,014	\$ 68,939	\$ 208,522	\$ 78,396	\$ 83,878	\$ 189,334	\$ 560,130
4.11. RESULT 4 Fixed Fee	\$ 9,846	\$ 5,001	\$ 7,199	\$ 5,968	\$ 5,065	\$ 12,901	\$ 4,300	\$ 4,300	\$ 11,577	\$ 33,078
RESULT 4 TOTAL COST + FIXED FEE	\$ 194,984	\$ 109,263	\$ 110,975	\$ 103,982	\$ 74,004	\$ 221,423	\$ 82,697	\$ 88,178	\$ 200,911	\$ 593,208
TOTAL COST ALL RESULTS + FIXED FEE	\$ 1,973,277	\$ 536,780	\$ 796,932	\$ 1,072,353	\$ 1,119,875	\$ 2,089,543	\$ 672,062	\$ 964,114	\$ 1,773,497	\$ 5,499,217
*Please note that this report includes expenditures and accruals through 9/30/12. The total cost varies from the total stated in the SF 425 for the 4th quarter of FY 12 as the SF 425 was through 9/28/12 per FHI 360 first closing of FY 12.										

1.3. Delhi Office Space Renovated and Staff Moved to Permanent Office

On February 1, 2012, IHBP moved to its permanent office at the fourth floor of Farm Bhawan, 14–15 Nehru Place, New Delhi, which was renovated using project funds. The UP staff continued to function from its temporary location in Lucknow. No official notice to close the UP office has been given by USAID.

1.4. Consultants to Government Hired

The following long-term consultants were hired and seconded to government agencies:

- Mr. Rajesh Rana (Program Officer, NACO): April 1, 2012–March 31, 2013 (assumed Account Director, Media Position on September 25 leaving Program Officer position vacant)
- Mr. Rajesh Rana (Account Director Media, NACO): September 25, 2012–August 24, 2013
- Ms. Neetu Singh (Nutrition Resource Platform [NRP] Technical Consultant): June 6, 2012–November 30, 2012

1.5. USAID Financial Review Conducted

USAID’s Regional Financial Management Office conducted a financial review of IHBP from June 13 to 15, 2012. On June 15, USAID presented key findings during a debriefing session attended by IHBP’s Chief of Party and Finance and Administration staff, as well as USAID’s COR. During this session, USAID indicated that they were generally “happy with the financial and administrative systems in place.”

1.6. FP Compliance Training and Online Certification Completed

In Year 2, all newly hired IHBP-FHI 360 staff completed the online training and new subcontractor-seconded staff will complete the course in October 2012.

2. Project Management – Technical

2.1. Work Planning for the Period July 2012–September 2013

With the consent of the COR, IHBP organized a 3-day planning meeting from May 9 to 11, 2012 attended by all IHBP and subcontractor staff and some HQ staff.

2.2. Work Plan for July 2012–September 2013 and Updated AMP Submitted to USAID – July 11 and 12, 2012

IHBP submitted the work plan for July 2012–September 2013 to the USAID COR on July 11 and the revised AMP on July 12. As earlier noted, USAID has not granted formal approval of this work plan and AMP.

2.3. IHBP Meetings with USAID COR Held in Year 2

From November 2011 to September 2012, IHBP held 13 meetings with the COR including the semi-annual performance review on November 1, 2011.

2.4. Key Meetings with Government Held in Year 2

In line with IHBP’s principle of working in close collaboration with government, IHBP held regular consultative meetings with government counterparts in MOHFW – IEC, FP, MH and CT Divisions, NACO and MOWCD. Key meetings worth citing are:

- Meeting with MOHFW Additional Secretary Desiraju and USAID – February 28, 2012 wherein MOHFW granted general approval for IHBP TA to MOHFW and NIHFW.
- Meeting with MOHFW Additional Secretary and Mission Director, National Rural Health Mission (NRHM) A. Gupta– May 11, 2012 wherein MOHFW approved four IHBP consultants to strengthen the IEC Division and a rapid capacity assessment of the IEC Division.
- Meeting with NACO Additional Secretary A. Johri – June 27, 2012 wherein general approval for IHBP Plan of Action for NACO was granted.

3. POAs Submitted to MOHFW IEC Division and CTD and to NACO

In early 2012, IHBP submitted draft POAs for collaboration with each of its government partners: MOHFW (IEC Division, plus NIHFW, FP and MH Divisions); MOHFW (CTD); NACO; and MOWCD.

3.1. POA with MOHFW – IEC Division

On May 3, 2012, IHBP submitted its draft POA as approved by USAID to MOHFW IEC Division, which includes:

- **Establishment of BCC Technical Support Unit in the IEC division** for TA to improve management and coordination of IEC/BCC interventions within MOHFW
- **Assistance in building capacity of the IEC Division comprising** training of national and selected state IEC staff, development of job aids and tool kits on various aspects of BCC work, and on-the-job mentoring of national-level staff
- **Development of NIHFW as a Center of Excellence** to train various cadres of MOHFW staff at national and state levels on BCC
- **Mentoring of a nodal institution to support the IEC Division** in designing, implementing and evaluating BCC programs
- **TA to develop and implement integrated BCC campaigns** to reposition FP and to promote MH, and strengthen advocacy, communication and social mobilization (ACSM) in the Central Tuberculosis Division (CTD)
- **Facilitating coordination** between national-level and state-level

3.2. POA on ACSM TB with CTD

On March 28, 2012, IHBP submitted the POA on TB ACSM to CTD, which will:

- Assist in planning and strategy development, including evidence gathering and research
- Strengthen capacity of TB IEC officers
- Place two BCC consultants
- Conduct orientations to media and media training for CTD officials
- Assist in developing champions/spokespersons

3.3. POA with NACO

On February 14, 2012, IHBP submitted its POA to NACO, which includes TA in:

- Establishing and operationalizing the National HIV/AIDS Communication Resource and Support Center (NHCRSC)
- Developing tools for planning and management of integrated BCC campaigns at national and state levels
- Hiring an ad agency to produce ready prototypes for selected BCC campaigns
- Seconding 13 BCC consultants to NACO (2 for NACO and 11 for NHCRSC)
- Conducting campaign evaluation studies

- Innovations on BCC (through NHCRSC)
- Developing a national campaign to sensitize health care providers to prevent S&D toward Persons Living with HIV (PLHIV)

3.4. Support to MOWCD

Following guidelines from USAID, IHBP is providing limited support to MOWCD. This comprises the ONA, providing two consultants for the Nutrition Resource Platform (NRP), and support in improving the ICT system in the NRP.

4. Accomplishments under Intermediate Results (IRs)

4.1. IR1 – Institution Strengthening: Institutions and capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels

This section describes IHBP activities and results to achieve institution strengthening and capacity building. In the original proposal approved by USAID, institution strengthening was the core of the IHBP approach. The vision was to first strengthen government agencies (MOHFW’s IEC Division and other program divisions, NACO, MOWCD) for BCC and, based on increasingly strengthened capacities, BCC activities at the national, state, and district levels (strategic planning, development of communication materials, mid-media, and IPC) would be implemented by these agencies with TA from IHBP. However, government agencies have not fully bought into the concept of institution strengthening. Based on discussions with government counterparts, the more realistic goal is capacity building of staff for BCC.

The capacity building goal applies mainly to MOHFW, CTD, and MOWCD. NACO has categorically stated that capacity building of staff is not a priority, since the HIV/AIDS communication program is already in an advanced stage. Rather than capacity building and training, NACO needs tools to guide IEC officers in various aspects of BCC programming and TA to support implementation of BCC activities.

The following sections describe the accomplishments of IHBP under IR1.

4.1.1. Organizational Needs Assessments for MOHFW and MOWCD Completed Rapid ONA for MOHFW Completed

IHBP completed a rapid assessment of institutional capacities and human resources for IEC/BCC planning, implementation, and M&E, which was approved during the May 11, 2012, meeting with the AS Secretary and NRHM Mission Director. IHBP submitted the draft summary report to USAID and the IEC Division in September 2012.

Objectives and methodology of the rapid ONA. The ONA covered the IEC Division and the FP, MH, CT Divisions as well as NIHFW. It aimed to update the findings from previous reviews on BCC capacity, gather information on action taken based on the reviews, and assess current human resource capacity for BCC in MOHFW. Aside from desk reviews, interview were conducted of key officials at the national level and in two states—Rajasthan and Orissa from May to June 2012. IHBP adapted the organizational and individual assessment tools developed by the C-Change project for the ONA.

Some Key Findings of the Rapid ONA

Enabling Environment for BCC. There is a significant gap between intent and implementation, as IEC/BCC continues to be low priority within MOHFW.

- The majority of IEC initiatives continue to be planned and implemented as one-off activities with weak situation analyses and M&E. Except for polio, most BCC campaigns in the last 2–3 years did not show integrated use of mass media, mid-media, and IPC.
- The IEC Division continues to be headed by a Joint Secretary who is charged with additional functions other than IEC, implying that IEC/BCC is not a high priority in MOHFW.
- The IEC Division is mandated to support most program divisions on BCC planning and implementation. However, the program divisions undertake BCC initiatives independent of the IEC Division.

Staffing, HR, and capacity of the IEC Division have significant issues.

- The recommendation from all reviews between 2008 and 2011 that the IEC Division be restructured and strengthened through BCC consultants has not been fully implemented, leaving the division today with only about 4 staff members (down from 16 in 2008) with media backgrounds.
- The current staff in the IEC Division is focused on mass media production and media placements .
- Job descriptions, where available, are outdated and reporting lines are unclear.
- There is no mechanism for systematic and ongoing capacity building of IEC or program officials.

Horizontal and vertical coordination and synergy are missing.

- Joint planning meetings or consultation between the IEC Division and other program divisions are not conducted and interactions are limited.
- Mechanisms and platforms like the IEC Coordinating Committee and biannual meetings with state IEC Bureaus—recommended by earlier studies—have been undertaken intermittently but not institutionalized.
- Communication between the IEC Division and state IEC Bureaus is limited to directives received by states regarding organization of advocacy events to commemorate certain occasions (e.g., observation of World Population Day) or activities for specific campaigns (mainly polio). All states visited felt that decisions within government are largely based on “precedence” and that innovation is not encouraged.

BCC programs at MOHFW have the following gaps.

- There is no overarching BCC strategy document at the national level. Communication strategies across all programs are represented by standardized two-page Annual Action Plans (AAPs) in the NRHM Program Implementation Plans (PIPs), and mainly detail budgetary allocations focused on mass media, with little variation over the years. Some states, like UP, have a well-defined, comprehensive BCC strategy, but their application has been negligible.
- There is little evidence of formative research and needs assessments by either the IEC or Program Divisions while designing BCC materials and messages.
- Materials development is the key activity focus for all divisions at MOHFW, with a “one-size-fits-all” approach.

- An outdoor campaign was evaluated by the Indian Institute of Mass Communication and the MCH-Star evaluation of Phase 2 of the NRHM campaign. However, there is still a need to institutionalize ongoing M&E of BCC programs.

ONA on BCC for MOWCD Completed

IHPB submitted the draft report of the ONA for MOWCD to USAID on July 27, 2012. On September 21, IHBP presented the findings of the ONA to Dr. Shreeranjana, JS, Integrated Child Development Services (ICDS) and his team. The JS acknowledged the challenges posed by the implementation of ICDS and the limited capacity and skills of staff. He asked IHBP to incorporate the framework for BCC that may be used by the staff to develop BCC interventions. He also asked IHBP to identify resources on BCC in the ONA report.

Study objectives and methodology of the ONA. The ONA aimed to assess institutional capacities and gaps in the Child Development Division of MOWCD for BCC. The methodology consisted of a desk research, and in-depth structured interviews in Delhi with officials from MOWCD, the Food and Nutrition Board, NIPCCD, and officers at UNICEF, and in two districts of UP (Hardoi and Maharajganj) with key officials and staff in the DOWCD at state, district, block, and field levels.

Some Key Findings

Inadequate national-level structure for BCC. There is no dedicated IEC division to carry out the BCC activities within MOWCD. The Media Unit is not technically nor technologically equipped to create and manage BCC-oriented materials and campaigns. There is no system to provide necessary support and guidance to the states on BCC.

Inadequate state-level structure for BCC. There is no structure nor staff to plan, implement, and evaluate BCC campaigns and activities in the state. At the district level, a dedicated position for managing BCC activities is absent.

Planning and monitoring. The state communication plan largely consists of item-wise cost estimates. There is no plan for undertaking BCC at the district level resulting in the absence of guidelines for IEC/BCC activities at *anganwadi* centers (AWCs) and during home visits. Monitoring of BCC activities, especially at the field level, is weak.

Capacity building. No regular or refresher BCC trainings are conducted for AWWs and field staff. There is no system to assess AWW training needs nor changes in their knowledge and skill levels as a result of training. In the case of trainings by development partners, supervisors and Child Development Officers are sometimes not aware of the training content; hence, there is no follow-up with AWWs.

Materials development and use. The communication materials developed are focused on providing information. IEC materials for use by AWWs in all districts are scarce. Charts and posters are prepared by the AWWs, but they have poor attention value for the target audience. Use of wall writings and pictorial demonstrations at AWCs and folk media like puppet shows and folk theater, was not evident.

4.1.2. Scoping Study of Nodal Organizations Completed

To identify and select a nodal organization, IHBP conducted a scoping study of potential organizations at the national level. Initial plans were to conduct the scoping study in one

state, but this was indefinitely postponed since there is no decision on the focus state for IHBP support. IHBP sent the scoping study report to USAID on August 24, 2012 and gave an oral presentation of the findings during an earlier meeting with the COR. IHBP is awaiting guidance from USAID on how to proceed.

Study Objectives and Methodology. The scoping study aimed to identify institutions at the national level and shortlist those that have the best potential to be strengthened by IHBP as the BCC nodal organization. Organizations were shortlisted based on the following: have led or implemented studies or projects in communication and/or capacity building in health at the national or state level, and, have experience working in IEC/BCC activities or the technical areas of MCH, FP, HIV/AIDS or TB with relevant government departments. Based on these criteria, 25 organizations were selected for further assessment.

From the 25 organizations, seven were identified based on the range of services they provide like formative research, message design, media planning and buying, implementation and rollout, education and training, M&E, and impact assessment. IHBP, then, conducted a more in-depth review of each of the seven organizations. This review consisted of an internal assessment of organizational capacity or potential based on discussions with personnel and review of organization documents, and an external assessment based on discussions with officials from the organization's clients. IHBP met with senior officials of each of the seven organizations prior to the in-depth review.

Based on this review, three organizations emerged as potential nodal organizations:

- Hindustan Latex Family Planning and Promotion Trust
- Population Foundation of India
- Public Health Foundation of India

In consultation with USAID and MOHFW, IHBP expects to select the nodal organization in October 2012.

4.1.3. Memorandum of Understanding (MOU) with NIHFW as Center of Excellence Finalized

The proposal to develop NIHFW as a Center of Excellence for capacity building of various health personnel categories on BCC emanated from the previous JS (IEC), Ms. Shakuntala Gamlin. To pursue this goal, IHBP initiated meetings with NIHFW senior officials starting in November 2011. NIHFW requested a formal letter of endorsement from MOHFW before it could make any commitments. The formal letter was not issued by MOHFW. Only after IHBP sent the minutes of the February 28, 2012, meeting with AS Health Desiraju endorsing IHBP support to NIHFW did NIHFW commit to IHBP TA. From March to August 2012, discussions ensued on the IHBP-NIHFW work plan that would form the basis for an MOU between IHBP and NIHFW. The MOU is being finalized for signing in October 2012.

4.1.4. Recruitment of 21 IHBP Consultants for National Government Partners Ongoing

As per the IHBP POAs submitted to national government partners and approved by USAID, IHBP will support 21 BCC consultant positions at the national level. These comprise four consultants to MOHFW IEC Division, two consultants to CTD, 13 consultants to NACO, and two consultants to the NRP. These consultants will support capacity building of government IEC staff and assist in various aspects of IEC/BCC programming by government.

Four Consultants to MOHFW IEC Division – Two Selected for Hiring

- **Consultant (BCC Capacity Building).** Will coordinate and manage capacity building activities with NIHFW, program divisions, and development partners.
- **Consultant (BCC Strategy and Campaigns).** Will help design and coordinate implementation of BCC strategies and campaigns.
- **Consultant (Media Management).** Will coordinate with media agencies on media planning and implementation of media plans.
- **Consultant (BCC M&E).** Will plan and oversee implementation of evaluation studies of mass media, mid-media, and IPC campaigns.

Status of MOHFW consultants as of September 30, 2012. IHBP posted the consultant application requests on DevNetJOBS in February 2012, and selected four candidates who met the required qualifications. The CVs and assessment done by IHBP were sent to the Director, IEC (IHBP focal person) on March 29, 2012, so that interviews could be arranged.

A panel of officials of the IEC Division and IHBP staff interviewed candidates on June 29, 2012. Only one candidate appeared for an interview. The interviews were rescheduled. IHBP reconsidered the potential candidates from the CVs that were received earlier for various positions and selected 12 candidates for interview in early August 2012. The IEC Division requested IHBP to postpone the interviews until after the meeting with the AS Health cum MD NRHM on September 20.

Interviews were held on September 27, 2012. Seven candidates agreed to be interviewed among those 12 shortlisted. Of the seven interviewed, two were selected—one for BCC Strategy and Campaigns, and the other for Capacity Building. IHBP will again review the previous applications received to shortlist candidates for the two other positions—Media Management and M&E. If no suitable CVs are found, IHBP will re-advertise these two positions in October.

Two Consultants for CTD – Two Selected, IHBP Employment Offers Declined

- **Consultant (BCC Capacity Building).** Will coordinate planning and management of capacity building activities in ACSM for CTD.
- **Consultant (BCC Campaigns).** Will help design and implement BCC campaigns and media plans.

Status of CTD consultants as of September 30, 2012. IHBP advertised the two consultant positions in DevNetJOBS in March 2012 and shortlisted candidates from CVs received by the April 16 deadline. With CTD officials, IHBP held two rounds of interviews (on June 13 and 19) and selected two candidates. The two declined the offer, since they did not agree to the salaries proposed that follow IHBP HR policy. IHBP will review the database for candidates and hold interviews again as soon as possible.

13 Consultants for NACO – One (Account Director, Media) Hired

- **Creative Development Officer (IEC)** (formerly titled Program Officer (IEC)). Will help plan and manage NACO BCC campaigns and assist BCC activities of SACSs.
- **Account Director (Media).** Will oversee media planning and implementation of media campaigns, including 360-degree multimedia campaigns.

- **National Coordinator (NHCRSC).** Will provide technical support in start-up, operationalization, and strengthening of NHCRSC, and supervise NHCRSC staff.
- **HIV/AIDS Repository Manager.** Will manage the physical and digital library and plan sourcing and collection of BCC products.
- **Manager, Communication Planning and Support.** Will plan BCC inventory, manage forecasting and distribution of BCC products, and support state rollout of AAPs and media plans.
- **Manager, Content Development.** Will develop content for mid-media and IPC.
- **Manager, Mass Media.** Will oversee mass media product development.
- **BCC Product Sourcing Officer.** Will source BCC materials from various stakeholders.
- **ICT Officer.** Will convert physical materials into digital products and catalogue them and support ICT needs of NACO and SACS.
- **Program Officer, Mid-Media.** Will develop mid-media plans with SACS, support rollout of mid-media activities.
- **Program Officer, Capacity Building.** Will develop and help implement BCC training plans for NACO and SACS.
- **Technical Officer, Research and Evaluation.** Will plan and manage evaluation studies.
- **Documentation Officer.** Will develop and implement a documentation plan and organize dissemination activities.

Status of NACO and NHCRSC consultants as of September 30, 2012. IHBP placed Mr. Rajesh Rana as Program Officer (IEC) in NACO effective April 1, 2012. In response to NACO's request to recruit an Account Director (Media), IHBP contacted candidates who had applied for the position in October 2011 under the USAID-funded Samarth Project. As most of the candidates shortlisted then had found other employment, IHBP, with NACO concurrence, advertised the position of Account Director (Media) in DevNetJOBS and in naukri.com. IHBP shortlisted five candidates in consultation with NACO. Interviews were conducted on July 11, 2012, by a panel composed of officials from NACO, FHI 360, and a private sector media expert. Of those interviewed, only Mr. Rajesh Rana (already hired as Program Officer, but who still applied for the Account Director position) was found suitable. Mr. Rana was hired as Account Director (Media) starting September 25, 2012, leaving the position of Program Officer (IEC) vacant.

NACO requested IHBP to rename the position of Program Officer (IEC) to Creative Development Officer (IEC) with a revised SOW. IHBP revised the SOW and advertised the position in August 2012. On September 17, interviews of shortlisted applicants were held. The interview panel included an ad agency practitioner plus members from NACO and IHBP. Two candidates were shortlisted, including an internal candidate from NACO. The two candidates are scheduled for interview by the AS NACO, so that a final decision on the nominee to the post can be made.

For NHCRSC, IHBP advertised the initial four positions in early March 2012, following approval from the Joint Director, IEC, on the SOW that IHBP drafted for each. The IHBP team summarized all applications received and submitted the resumes and analysis for all applicants plus a recommended shortlist to NACO on March 22. No response was received from NACO, despite follow-ups. In June, NACO informed IHBP that they would like the SOW to be tweaked to new needs in NHCRSC. NACO requested IHBP to put on hold all recruitments for NHCRSC until the revised SOWs are formally approved by the AS NACO. In late August, NACO requested that seven additional consultants be added to the four for

NHCRSC. In September, IHBP drafted SOWs for all 11 consultants in collaboration with NACO. In end September, IHBP advertised the 11 positions as approved by USAID and NACO. Shortlisting and interviews are planned in October.

Two Consultants for the NRP, MOWCD – IT Advisor Hired and Chief Coordinator Selected for Hiring

- **IT Advisor.** Will provide technical support in the start-up, operationalization, and strengthening of NRP's IT infrastructure and serve as IT administrator.
- **NRP Chief Coordinator.** Upon request of MOWCD, this position has been renamed as Chief Coordinator from the previous title of Coordinator and will be part-time position (LOE of 10 – 12 days per month) which will support and guide start-up, operationalization and strengthening of the NRP.

Status of MOWCD consultants as of September 30, 2012. IHBP advertised the two positions in DevNetJOBS in early 2012. Interviews of shortlisted applicants were held. The interview panel comprised senior officials of NIPCCD, Food and Nutrition Board and IHBP staff. Applicants also took a written test. The panel unanimously selected one candidate for the NRP Technical Officer position, but rejected all candidates for the NRP Coordinator position. The Technical Officer, Ms. Neetu Singh, was hired effective June 6, 2012.

IHBP initiated a fresh search for the Chief Coordinator position in June 2012. Interviews of shortlisted candidates were held on July 20 and 25, and a candidate was selected. IHBP is processing the candidate's documents for USAID approval and subsequent hiring.

4.1.5. Capacity Building for BCC

Training Module on Community Mobilization and IPC for Frontline Workers Developed and Pilot-Tested with NIHFW

In May 2012, NIHFW requested IHBP to help finalize a module and conduct training for ANMs on community mobilization and IPC. IHBP reviewed NIHFW's existing training materials and concluded that they needed revision. IHBP, thus, revised the existing training module and materials for frontline health workers with a focus on mid-media and IPC. It was agreed that two trainings of ANMs in New Delhi would be used as pilot tests of the revised module.

The two rounds of 3-day trainings were held for ANMs at NIHFW in New Delhi from July 17 to July 19, and July 23 to July 25. IHBP and NIHFW staff facilitated the training attended by a total of 58 ANMs. Pre- and post-tests were administered to participants. Results demonstrated substantial knowledge gains by trainees – an increase of 42% and 56% for the first and second trainings, respectively. An evaluation was also done get trainee feedback on each session and recommendations for improvement of the training. Based on the evaluation, IHBP is finalizing the module.

Media Training for CTD Officials and TB Orientations for Media Practitioners – PR Agency Selected

The media training, part of the CTD POA, aims to build the skills of CTD officials in working with media, public speaking, and responding quickly to inaccurate reporting on TB. The orientations for media practitioners aim to improve the knowledge of media people on TB and related issues, promote accurate reporting, and engage them to improve public opinion and action for TB in India.

In June, IHBP sent the RFP for the media training and orientations of media practitioners to 14 PR agencies. The selection process has been completed and IHBP is in the final stages of issuing the purchase order to the selected agency. Activities will start in October.

4.1.6. Media Monitoring of TB Reporting

As a complement to the media training of CTD officials and TB orientations for media practitioners, IHBP will help CTD in tracking media content on TB in order to monitor media reports and detect negative reporting for quick response by CTD. The RFP has been issued to PR and media agencies and proposals are due on October 8, 2012.

4.1.7. Assistance to BCC Resource Centers Ongoing

IHBP is providing TA to NACO in establishing and operationalizing NHCRSC and to MOWCD in launching and operationalizing the NRP. It will also initiate support to MOHFW-NIHF in strengthening a BCC Resource Center.

NHCRSC in NACO – TA Initiated

NACO envisions NHCRSC as the gateway for all HIV/AIDS-related communication activities. Expected to be fully operational in March 2013, NHCRSC will serve as a Technical Support Unit to the IEC Division of NACO, complementing the work of the IEC Division. It will function as a media resource and BCC program support and documentation center for NACO and SACS. The fiduciary functions of budgeting, planning, and obtaining approvals through the government system will continue to be with the IEC Division.

Support for 11 Consultants Ongoing

IHBP is in the process of recruiting of 11 consultants for NHCRSC as earlier described.

Support for Digital Library Ongoing

IHBP will support the development of a digital library as a media e-resource center, which will serve as a portal of tested BCC management tools and materials for all IEC staff at national and state levels. Knowledge dissemination through the digital library will be targeted to users of NHCRSC, enabled through a secured interface.

IHBP drafted an RFP to hire an ICT agency to design and develop the library in March 2012, but, upon instruction by NACO, has withheld the RFP's release pending its final approval by the AS NACO. This RFP was further revised based on meetings held with NACO in September 2012. The final approved RFP is planned for release in October. IHBP hopes to start the digitization work in December 2012.

The NRP in MOWCD – TA Ongoing

Support for Two Consultants

On September 22, 2011, IHBP submitted a draft action plan to assist the launch and operationalization of the NRP at MOWCD. Intrinsic to the plan is secondment of two consultants for the NRP, as requested by MOWCD. As reported previously, IHBP hired the IT Advisor in early June 2012, and is in the process of hiring the Chief Coordinator.

Support for ICT System Improvements

In April 2012, IHBP conducted a quick assessment of actions needed to operationalize the NRP. In June, with the IT Advisor in place, IHBP provided technical support to improve the

IT infrastructure. From April to June, IHBP assisted in improving the design of the NRP portal. The portal is ready to be launched as an interactive, virtual, information technology-enabled platform where different stakeholders in nutrition can share knowledge, experience, and resources.

4.2. IR2 Knowledge and Attitudes Improved: Accurate and appropriate knowledge/attitudes increased in individuals, families, communities, and providers at district, state, and national levels

In Year 2, the major accomplishments of IHBP under IR2 centered on its support to MOHFW in planning and implementing two integrated BCC campaigns: a multimedia campaign to reposition FP from limiting to spacing of births and a campaign to promote maternal health. Major accomplishments under IR2 are discussed below.

4.2.1. FP Repositioning BCC Campaign – Communication Materials Developed, Pretested, and Finalized, and Prototypes Handed over to FP Division, MOHFW **Brief Background of the FP Repositioning Campaign**

In August 2011, the FP Division requested IHBP to help in developing a BCC strategy to reposition FP, from limiting of births to spacing of births by three years. To follow up on agreements from this meeting, IHBP developed a BCC Strategic Plan to reposition FP, which was submitted to the FP Division on September 19, 2011, and approved on September 28. The BCC plan to reposition family planning aims to:

- Effectively communicate the benefits of birth spacing to MCH
- Promote the use of contraceptives (oral contraceptive pills, IUCD and condoms) as modern spacing methods
- Address myths and misconceptions around contraceptives
- Encourage people to seek safe and effective services from wherever they are available, government or private providers

The plan targets couples of reproductive age as the primary audience and influentials like family members, community leaders and health providers as secondary audiences. It initially focused on 11 states—the eight Empowered Action Group (EAG) states of Bihar, Chhatisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Orissa, UP, Uttranchal—plus Gujarat, Haryana, and Assam. In July 2012, the coverage was expanded nationally. The overall strategy and the creative campaign utilizes mass media, mid-media, and IPC channels.

Key Accomplishments as of September 30, 2012

In Year 2, IHBP completed development, pretesting and production of communication (mass media and print) materials with support from an ad agency selected through a bidding process. By September 30, IHBP handed over the Hindi-version prototypes of the following materials to the FP Division:

- Two TVCs – *Mehnat* (60 seconds) and *Cycle Race* (30 seconds)
- Two radio spots – 60 and 30 seconds, respectively, corresponding to *Mehnat* and *Cycle Race*
- One song – two versions (180 and 90 seconds)
- Jingle – three variations, 6 seconds each
- Four posters (design only)
- Four billboards based on posters (design only)
- Four wall paintings (design only)

One flipchart and four flyers are being finalized based on pretest results. As per agreement with MOHFW and USAID, all media placements, translations, and mass production of print materials will be undertaken by MOHFW using government funds.

The following table summarizes the FP Repositioning materials:

Type of communication material	Number	Status
TVCs <ul style="list-style-type: none"> • 1 x 60 secs – Mehnat 60-second spot, slice-of-life showing 3 couples who sacrificed for their children and always gave them the best. The spot conveys that the easiest of all their sacrifices was the adoption of an effective spacing method. Spacing methods include condoms, OCPs, and IUCDs with call to action to contact your nearest hospital or health center for more information. • 1 x 30 sec – Cycle Race Highlights the positive impact of spacing on the health of the mother and her children through the event of a cycle race in rural India. Spacing methods include condoms, OCPs, and IUCDs with call to action to contact your nearest hospital or health center for more information. • 3 x 30 secs each Edits of the 60-sec spot into three unique spots. One on each method: intrauterine contraceptive device (IUCD), condom, and pill. 	2+3	On air
Radio Spots <ul style="list-style-type: none"> • Mehnat – 60-sec • Cycle Race – 30-sec Audio versions of the 2 TVCs	2	On air
Song – 180-sec Conveys the benefits of spacing through a melodious song. Jingle – 15-sec Khushi ka Mantr rakhna Yaad – Doosra baccha teen saal baad Can also be used as a mobile ringtone.	1	Submitted Prototypes ready
Posters – one each on: <ol style="list-style-type: none"> 1. Benefits of spacing 2. Maternal health 3. Inter-spousal communication 4. Three temporary methods of spacing 	4	Submitted Prototypes ready
Wall Painting/Billboards Same as 4 posters	4	Submitted Prototypes ready
Street play scripts Benefits of spacing and three temporary methods of spacing	4	Finalizing
Flipchart 10 pages with color photos of couples portraying benefits of FP and info on the specific methods: IUCD, etc. (detail out); IUCD poster	1	Finalizing (based on pretest results)

Type of communication material	Number	Status
Leaflet – one each on: <ol style="list-style-type: none"> 1. Benefits of spacing 2. Condom (use and benefits) 3. Oral contraceptive pill (OCP) (use, benefits, and limitations) 4. IUCD (use, benefits, and limitations) 	4	Finalizing (based on pretest results)
Mobile (ICT adaptation)		Under development

Pretest of TV and Radio Spots, Jingle conducted. The pretest of TV and radio spots, and jingle was conducted in March 2012 in UP and Rajasthan through 12 focus group discussions (FGDs) of currently married rural men and women (aged 18–29 years) with at least one child. The findings revealed that respondents generally understood and empathized with the key messages of the materials and found them attractive, credible, and relevant. There were no gross negative reactions. The findings identified improvements in language, visuals, and sound, which IHBP used to revise the materials.

TV and Radio spots produced. The production shoot of the revised TV spots was held from May 23 to May 24, 2012, in Mumbai. IHBP presented the final revised spots to USAID on June 15.

Prototypes of TV and radio spots handed over to and aired by FP Division, MOHFW. In June 2012, the FP Division asked IHBP to provide copies of the spots (and prototypes of the four posters) for distribution to the states for the events to commemorate World Population Day on July 11. The states would air the spots on district channels while the FP Division would air the spots on national channels (Doordarshan). IHBP delivered copies of the TV and radio spots, and prototypes of the four posters, in time for the July 11 events. With the national media launch on July 11, 2012, the campaign now has a national coverage.

Four Posters (with Billboard Versions) on FP Repositioning Developed, Pretested, and Finalized

IHBP produced prototypes of four posters. Visuals of the posters are drawn from the characters in the TVCs. The posters were finalized based on results of the pretest done through individual interviews of married men and women held in UP in June 2012.

One FP Flipchart and Four FP Flyers Developed, Pretested, and Being Finalized

Aside from the four posters, IHBP developed a flipchart and four flyers for IPC activities by frontline workers and distribution to target couples. These materials were identified as needs after reviewing the existing materials. Development of these materials was done in consultation with the FP Division and USAID. These materials are being finalized based on results of the pretest conducted in UP and Jharkhand in April 2012.

Material	Purpose	Target audience	Key messages
A 10-page flip chart	To establish the concept of spacing by focusing on health and other benefits To provide information on the different methods	Woman	<ul style="list-style-type: none"> • 3-year spacing leads to better health for the mother and children. • Spacing methods include condoms, OCPs, and IUCDs. • Spacing helps in nurturing your child through better education, clothing, and food. • Plan your finances before planning for your next child. • Let your first child be self-reliant before planning your next. • Thousands of people have spaced at least 3 years between their children and lead happy lives. • Always consult the ANM/doctor before adopting OCPs or IUCDs. • You can buy condoms and OCPs from your village ASHA or nearest medical shop.

4.2.2. Maternal Health Integrated BCC Campaign – Communication Materials Developed, Pretested, Produced, and Handed Over to MOHFW MH Division

Brief Background of the MH BCC Campaign

In response to a request received from the MH Division for support in planning and implementing a BCC campaign to promote maternal health, a meeting was held in October 2012 between IHBP, USAID, and the MH Division.. During this meeting, the MH Division gave the following guidelines:

- The MH campaign should target the eight EAG states, plus the state of Assam.
- It should include a major demand-generation component with a focus on the new government scheme, JSSK
- The focus should be on MH only; child health should not be included in the campaign.
- Targeted health providers will be ASHAs and ANMs.

It was agreed that IHBP will support development and production of prototype creative materials (TV, radio, print) in Hindi, while MOHFW will fund reproduction/replication and mass media placement and all translations.

Key Accomplishments as of September 30, 2012

Integrated BCC Plan for Maternal Health Developed and Approved by MH Division.

IHBP developed a strategic BCC Plan, approved by the MH Division in late October 2011, using mass media, mid-media and IPC channels. The plan promotes the following maternal health practices:

- Early registration of pregnancy and completion of at least four antenatal care (ANC) visits
- Consumption of 100 IFA tablets during pregnancy
- Delivery and 48 hours' stay in a health facility
- JSSK and its benefits

The primary target audience for this campaign is couples within the 15–29 year age group while the secondary audiences comprise influentials like other family members (mother-in-law), community leaders and frontline health workers.

Communication Material Prototypes (TV, radio and print) Handed Over to the MH Division. By September 30, 2012, IHBP completed development, pretesting and production of Mass media materials with support from an ad agency selected through a bidding process. Hindi version prototypes of the following materials were handed over to the MH Division:

- One 60-second TVC on early registration of pregnancy and four ANC visits
- One 30-second TVC on consumption of 100 IFA tablets during pregnancy
- One 30-second TVC on institutional delivery and 48-hour stay in a health facility
- One 30-second on JSSK entitlements
- One radio spot corresponding to each TVC or four radio spots
- One 10-second jingle
- One 180-second song
- Four posters
- Four billboards (based on poster design)
- One board game (snakes and ladders)

The creative materials raise the question “*Why take a chance...*” with something as important as the health of mother and baby, and then point them toward the desired actions. The execution of the materials proposed have humorous yet emotional appeal.

IHBP developed and finalized four street play scripts for use during mid-media activities. One flipchart was developed but finalization but is on hold based on the request of the MH Division. IHBP will use images and text from this flipchart for adaptation to a mobile phone application for use by frontline health workers in Year 3. IHBP submitted four leaflets on the danger signs during pregnancy, healthy eating and rest during pregnancy, IFA tablets, and father’s responsibility during pregnancy, to the MH Division and await their feedback prior to pretesting.

The following table summarizes the MH communication materials.

Type of communication material	Number	Status
<p>TVCs 1 x 60 secs – GRANDMOTHER (4 ANC) In a humorous tone, the spot tackles the resistance to ANC by elders. The TVC was developed on the role of a mother-in-law in decision making on health care during a pregnancy in the family. It encourages pregnant couples to visit for an ANC at the earliest possible time and to opt for a safe delivery. Also has a shorter 30-sec version. 1 x 30 secs – POTATO BAG (IFA) Tackles the resistance to IFA consumption during pregnancy. Works on a simple, humorous rural analogy. Also has a 15-sec version. 1 x 30 secs – JALDBAAZI (Institutional delivery) Highlights the importance of childbirth in a health setting and emphasizes the need to stay in the health facility at least 2 nights after the delivery. Also has a 15-sec version. 1 X 30 sec – LADDOO (JSSK benefits) Promotes the “free” services available under the GOI JSSK scheme. Does it with a twist of humor in a family celebration. Also has a 15-sec version.</p>	<p>4 + 4 (shorter versions)</p>	<p>All 60/30 sec masters final pretested versions submitted to MH Division</p> <p>Shorter versions in final post-production</p>
<p>Radio spots x 4 (60 secs x 1 + 30 secs x 3) Adapted audio versions of the TVC.</p>	<p>4</p>	<p>Final pretested versions submitted to MH Division</p>
<p>Song – 180 secs Conveys the key messages and benefits of safe motherhood through a melodious song. Jingle – 10 sec Chance Kyon Lena Hai Can also be used as a mobile ringtone .</p>	<p>1</p>	<p>Final pretested version submitted to MH Division</p>
<p>Posters Poster 1: Go for 4 ANC visits during pregnancy Poster 2: Encouraging consistent consumption of 100 IFA tablets Poster 3: Encouraging institutional delivery Poster 4: Ensure healthy eating and rest during pregnancy</p>	<p>4</p>	<p>Final pretested versions submitted to MH Division</p>
<p>Wall paintings/billboards - As above</p>	<p>4</p>	<p>Submitted to MH Division – Prototypes ready</p>
<p>Street play scripts on four thematic areas:</p> <ul style="list-style-type: none"> • Completion of four ANC visits • Consumption of 100 IFA tablets • Institutional delivery with 2 nights (48 hours) of stay • Promotion of JSSK 	<p>4</p>	<p>Finalized</p>

Type of communication material	Number	Status
Flipchart - Draft flipchart prepared with a story line and photos woven around key behaviors.	1	Draft presented to MH Division prior to pretesting. MH Division suggested exploring possibility of adapting the existing Safe Motherhood booklet instead developing a new flipchart. They were keen on using some of the flipchart content for adaptation to mobile apps.
Leaflet Designed as interactive takeaway material after IPC/community meetings. The leaflets are on: <ul style="list-style-type: none"> • DANGER SIGNS during pregnancy • EATING HEALTHY and RESTING during pregnancy • IFA tablets • How to be Husband No. 1 (father's responsibilities during pregnancy) 	4	Draft submitted to MH Division, feedback awaited prior to pretesting
Board Game A fun, interactive "snakes and ladders" game that encourages players to reflect on behavior barriers and triggers that can result in safe pregnancy and child birth.	1	Final pretested version submitted to MH Division
Mobile (ICT adaptation)		Being developed

Pretest of TV and Radio Spots, Song and Jingle Conducted. The pretest of the TV and radio spots, song and jingle was conducted in May 2012 in UP. The pretest used FGDs among currently married women (18–29 years of age), husbands of currently married women (18–29 years of age) and their mothers-in-law. The findings showed that the materials and slogan (*why take a chance*) were understood and well received by the respondents and there were no negative reactions. Key items of information were: the term JSSK is not recognized (respondents are more familiar with JSY, the previous scheme), and the concept "two nights" is better understood than "48 hour. IHBP used findings to revise and finalize the materials.

Four TVCs and Four Radio Spots Produced and Handed over to MH Division. The production shoot of the four TVCs was held in Mumbai in the last week of July. The prototypes of the TVCs and radio spots were submitted to the MH Division in September 2012. IHBP is producing shorter versions of the TVCs for submission in October.

Four Posters and One Board Game Developed, Pretested, and Finalized, and Prototypes Handed over to MH Division

Four posters developed and pretested. To support mass media with IPC activities, IHBP developed four posters corresponding to the messages of the four TV spots. The posters were pretested in UP through individual interviews of married women aged 18 – 29 years, and of husbands of current married women of the same age range in August 2012. Findings were used to make revisions to the posters.

One board game—“Snakes and Ladders”—developed and pretested. IHBP developed an interactive “snakes and ladders” game for use during education activities. The game is an enjoyable tool for group sessions among target women or couples. The game describes the right and wrong decisions taken during pregnancy and their effects on mother’s and child’s health. The messages in the game are related to positive and negative behaviors on MH-related issues. The game was pretested in UP through simulated group sessions wherein women played the game, led by an ASHA. Results revealed that the game had high appeal and entertainment value, at the same time, respondents readily comprehended the messages. Findings were used to finalize the game.

Four street plays developed. IHBP developed four street play scripts on the four MH themes for use during community folk theater activities.

The finalized versions of the posters, board game and street play scripts were submitted to the MH Division for final approval on September 20, 2012.

4.2.3. Assistance to Mid-Media and IPC Activities for FP and MH Campaigns Initiated

To reinforce and provide depth to messages in the mass media campaigns for FP and MH, IHBP will support implementation of mid-media and IPC activities in selected states. IHBP will also organize a *national-level orientation on the FP and MH campaigns for all state IEC, FP and MH Program Officers* to orient them on the campaign, the proposed media plan, and mid-media and IPC materials, and training needs at the local levels. This orientation is planned for October 2012. IHBP is preparing an orientation and implementation handbook to guide the states in implementation of mid-media and IPC activities to support the media component of the FP and MH campaigns.

4.2.4. Two Safe Motherhood Posters and Safe Motherhood Logo Developed, Pretested, and Handed over to the MH Division

The MH Division requested IHBP assistance in designing two posters and a logo for the Safe Motherhood Day event on April 11–12, 2012, in Jaipur. In response, IHBP designed, pretested, and finalized two posters (one on the benefits of safe motherhood and one on JSSK entitlements) and one logo (an adaptation from the proposed logo for the MH BCC campaign). IHBP printed 50 copies of each poster and handed them over to the MH Division. During the inauguration session of the National Safe Motherhood Conference on April 11–12, 2012, in Jaipur, the Minister of State for Health, GOI, and the Health Minister, Government of Rajasthan, distributed prototypes of the two posters and copies of the logo to the state-level participants. MOHFW’s plan is to display these posters in primary health centers in NRHM priority states.

4.2.5. Review of Good Practices on BCC on FP, MCH, HIV/AIDS, and TB Completed

In Year 2, IHBP completed the reviews of good/best practices on BCC on FP, MCH, HIV/AIDS, and TB that were initiated in Year 1. These reviews gathered information on successful BCC programs in India and neighboring South Asian countries, and assessed factors influencing success of these activities that could be replicated by the project. The reviews first searched communication interventions on the specific program areas available through the Internet, publications, or any public domain. Based on the list of communication interventions, a shortlist was identified that could be reviewed on the following criteria:

- Has documented evidence of impact – either quantitative or qualitative or both
- Addresses both demand generation and supply side of behavior/social change

- Is based on partnerships with the community and/or the private sector and/or integrated with government structures and systems
- Has a clear and documented plan for strategic communication and integrates some innovations
- Uses more than one of three complementary approaches for SBCC (advocacy, community mobilization, and BCC)
- Has the potential for scale and sustainability

IHBP is preparing monograph versions of the review reports for publication and dissemination.

4.2.6. Cinema Ad Recall and Evaluation Study for NACO Completed

IHBP, as requested by NACO, evaluated the effectiveness of NACO's 40-second spot on sexually transmitted infections (STIs) called *Darr*, which was screened in 2,720 digital cinema theatres from December 9, 2011 to January 17, 2012. IHBP, through a contracted research agency, conducted exit interviews of 1,472 people coming out of shows in cinema theaters in Andhra Pradesh, Tamil Nadu, Gujarat, West Bengal, Punjab, and UP. The study revealed that the spots had high recall and understandability. It confirmed that digital cinema is a good medium for targeted campaigns, especially to target young, married couples.

4.2.7. Red Ribbon Express Spots for NACO Dubbed

On January 25, NACO requested IHBP support in dubbing TV spots on ICTCs, prevention of parent-to-child transmission of AIDS, stigma and discrimination, and youth in nine languages: Assamese, Bengali, Gujarati, Kannada, Malayalam, Marathi, Oriya, Tamil, and Telugu. These spots were produced by the Johns Hopkins University Center for Communications Programs (JHUCCP) and were to be shown during the Red Ribbon Express train advocacy activity. IHBP was able to complete this activity and turned over the dubbed spots to NACO on the agreed-upon date.

4.2.8. Internet Campaign on HIV/AIDS for NACO Developed

In November 2011, at NACO's request, IHBP developed an Internet campaign targeting youth. The campaign was planned for launch on World AIDS Day (December 1, 2011). IHBP developed creative materials on S&D and condom promotion and contracted a media agency for website placements. However, NACO postponed the campaign and recently requested IHBP to shelve it and develop a new campaign concept on S&D.

4.3. IR3 Community Platforms, Organizations, and Key Individuals (Influencers) Support Improved Health Behaviors

4.3.1 Background to IR3 Implementation in Year 2

To create a supportive community and social environment for healthy behaviors, IHBP planned to engage key influencers in the community; develop the capacity of individual "role models," community influencers, groups, and organizations to speak publicly about health issues; and strengthen existing or form new alliances for health. As per the task order, all IR3 activities were to be implemented in IHBP's focus state. Considering the current lack of a focus state and the thrust to assist national-level activities, IHBP support to states and districts has been minimal. However, IHBP continues to see the importance of demonstrating that mid-media and IPC are essential to changing behaviors targeted by any mass media or multimedia campaign.

Considering this scenario, in Year 2, IHBP obtained concurrence from USAID and MOHFW to provide limited support to community mobilization and IPC activities anchored on the national-level BCC FP repositioning and MH campaigns in a total of six blocks in three districts in two states. To this end, IHBP exerted significant efforts to prepare for the launch of mid-media and IPC activities in tandem with the launch of the mass media components of these two campaigns.

4.3.2 Accomplishments under IR3

Grants Program Developed

The IHBP task order originally approved by USAID envisaged the grants program to be rolled out in 10 districts of UP through NGOs in Year 2. The objective of this grants program was for local NGOs to supplement government BCC efforts targeting families and individuals to improve health knowledge, attitudes, and behaviors through cost-effective, innovative, and scalable BCC activities at the village level. Since this plan could not be executed, in Year 2, IHBP planned for implementation of the grants program in six blocks in three districts of two states as stated above.

In accordance with the above developments, IHBP budgeted a total of US\$720,000 to grants for the period September 2012–July 2013. Of this, US\$450,000 would be allocated for grants on FP and MH and \$150,000 would be set aside for ICT-related pilots. In addition, a sum of \$120,000 would be allocated for HIV and TB activities, though these would be considered only once the FP/MH grants had been rolled out.

Grants Manual Drafted and Districts Selected

On February 13, 2012, IHBP sent a draft Grants Manual to USAID for approval. On May 8, 2012, the COR notified IHBP that, as per the task order, the manual is not a deliverable and, therefore, does not need USAID approval. However, it is FHI 360's responsibility to ensure that the manual complies with the grants procedures under the IHBP contract with USAID.

From May to August 2012, IHBP revised and refocused the grants program for the pilot districts and developed draft versions of the manual, expression of interest, and RFP to be issued to potential grantees. In addition, IHBP scoped eligible NGOs in UP and Rajasthan, which, as agreed with USAID and MOHFW, were the two states for grants implementation. UP and Rajasthan were selected because they have poor FP and MH indicators, are priority states for NRHM, and are fairly accessible to Delhi, thus facilitating provision of TA by IHBP. FP grants would be implemented only in UP, while MH grants would be implemented in both UP and Rajasthan.

To select appropriate districts, IHBP mapped all districts in the two states using key FP and MH indicators (DLHS 3, 2007–08). In August 2012, IHBP shortlisted Hardoi and Sitapur in UP and Bharatpur in Rajasthan as districts for the grants program. In all, around 15–20 grants each covering an average population of 50,000 per block across six blocks (two blocks each from Sitapur, Hardoi, and Bharatpur) were envisioned.

In August, USAID requested IHBP to focus only on UP for the grants initiative. On August 21, 2012, IHBP met the NRHM Mission Director of UP, to seek support from the district administration of the two selected districts. On August 23, the state government sent a directive to the District Magistrates of Sitapur and Hardoi asking them to extend all support to IHBP as required. IHBP staff also undertook exploratory visits to the two districts to gain a

better understanding of existing health services and community-level issues. The manual and forms were further revised to accommodate the latest scenario.

Internal Workshop to Identify Community Mobilization and IPC Activities for Grants Support Organized

In July, IHBP organized a workshop to discuss and shortlist promising innovations in community mobilization and IPC for grants support that was attended by staff from IHBP and its partners, Popcouncil, PSI, and PCI. The workshop output was a descriptive listing of activities, which the grants program could support to supplement the mass media components of the FP and MH campaigns.

Implementation of Grants Program Decelerated (as per USAID Instruction)

In the work plan for July 2012–September 2013 that IHBP submitted to USAID, the plan was to complete awarding of a significant number of grants during September–November 2012 so that field activities could commence starting November 2012. In August, USAID instructed IHBP to move slowly on the grants program for UP. As of the end of September 2012, these instructions remain in effect.

4.3.2. Reviews of Community-Based BCC Platforms, and Incentives and Community Recognition Schemes Completed

Evidence Review of Community-Based Platforms for BCC

IHBP subcontracting partner PSI conducted a desk review to identify effective platforms that have been used at the community level to empower people vis-à-vis their health actions. The review covered 13 studies, which included studies elucidating the role of behavior change interventions in influencing maternal and neonatal health outcomes and studies that described and analyzed various approaches adopted and implemented in health programs to bring about positive behavior change. The study findings clearly show a significant role of community-based platforms in influencing women's ability to seek care that affects their health. PSI submitted a draft report and presented the findings to IHBP on November 21, 2011.

Review of Incentives and Community Recognition Schemes

This Internet review includes interventions implemented across India, Bangladesh, Nepal, Pakistan, and Sri Lanka. It primarily covered large-scale, national-level programs, like the Asha scheme of India, the Lady Health Workers Scheme of Pakistan, Shastho Shebikas of Bangladesh, and the Female Community Health Worker Program of Nepal. It touched on how community interventions using community health workers and volunteers have evolved and scaled up across the countries based on their experiences. PSI submitted the draft report and made a presentation to the IHBP team on November 21, 2011.

4.4. IR4 Vulnerable Groups Empowered: Vulnerable Communities Empowered to Seek Health Services and Products

4.4.1 Accomplishments under IR4

In Year 2, there was limited activity in pursuit of IR4. As part of its POA to NACO, IHBP planned to develop and support implementation of a multimedia campaign on stigma and discrimination targeting youth and health providers. However, prolonged discussions on the POA with NACO and its late approval by the AS NACO did not allow for launch of this activity. The only activity that was initiated was the activity in the POA on development of TB champions (those affected directly or indirectly by TB) as spokespersons for TB.

Development of TB Champions/Spokespersons – Ongoing

IHBP, with the TB Partnership based in New Delhi, agreed to identify champions/spokespersons from people who either are or were infected by TB, or their families and caregivers. IHBP would then assist the TB Partnership in building the capacity of the identified people in a phased manner to strengthen their skills and motivation to interact with key stakeholders—policy makers, elected representatives, program managers, state and district administration, community leaders, and the media—and voice their need for services, support, and equal and equitable treatment at all levels.

The TB Partnership facilitated the establishment of a selection committee composed of representatives from each of the Partnership's six thematic groups, namely, Advocacy, Operational Research, Public-Private Mix, Service Delivery, TB/HIV Co-Infection, and Women and Childhood TB. IHBP organized an orientation for the members of the selection committee at the IHBP office in New Delhi on August 23, 2012. During this orientation, the committee members identified the selection criteria and the content of the application template and finalized the selection process for TB champions.

By the end of September, IHBP was working on the procurement process to hire an agency to assist in the capacity building of selected TB champions and developing an advocacy toolkit for use by these champions.

5. Knowledge Management – Accomplishments

5.1. IHBP Website Developed and Launched

In the last quarter of 2011, following a competitive process, IHBP awarded a contract to New Concept Information Systems to design and develop an interactive project website. USAID approved the IHBP website domain and design. Based on this, IHBP developed a beta site that was revised based on feedback from various sources. The revised beta version (English) was approved by USAID on March 26, 2012. The IHBP website was launched in April 2012 after completing the formalities of site and domain transfer.

The IHBP website (with a web-based Intranet component) enables stakeholders to learn about the project. It also contains key IHBP products, such as IEC/BCC materials, training modules, and reports. The IHBP website URL is <http://www.ihbp.org>.

5.2. Four Quarterly Newsletters Disseminated

On September 14, 2011, USAID modified the IHBP task order allowing the project to produce and disseminate quarterly, instead of monthly, newsletters. IHBP produced and circulated four newsletters in Year 2.

5.3. Knowledge Management Strategy Approved by USAID

USAID approved the final draft version of IHBP's Knowledge Management Strategy on October 24, 2011, with some suggested revisions. IHBP finalized the strategy incorporating these suggestions. Rollout of the knowledge management strategy and project orientation to IHBP staff was completed in the following quarter (January–March 2012).

5.4. Knowledge Sharing of SBCC Innovations in Uttar Pradesh Organized

On October 11, 2011, IHBP sponsored a statewide knowledge-sharing meeting on "Innovations in SBCC" as part of the regular forums organized by the Health Partners Forum

in UP. Several leading organizations in UP implementing MCH and FP/RH projects participated.

5.5. Monograph Series on Completed BCC Reviews Being Developed

As earlier cited, IHBP is preparing monographs of the Good Practices Reviews (on FP/RH, MCH, HIV/AIDS and TB) and two summary reviews (Community Incentive Schemes and Community Platforms). For this task, IHBP hired a consultant (who was also tasked with developing the training module on community mobilization and IPC) in late June 2012, but the consultant cut short his consultancy after completing the training module. An alternative consultant has been approved and will prepare the monographs.

6. Leveraging Accomplishments

6.1. Leveraging Desk Review Completed

In late 2011, IHBP completed the leveraging desk review, which was submitted to USAID for comment at the end of January 2012. USAID declined commenting on this document.

6.2. International and Local Consultants Recruitment Pending

The consultancy of Gary Saffitz, a replacement for international consultant, Tennyson Levy, who fell ill, was approved on November 17, 2011. Mr. Saffitz was hired and finalized the desk review. Unfortunately, Mr. Saffitz could not continue with his consultancy, since he found long-term employment elsewhere. IHBP immediately recruited a suitable replacement and, on February 7, 2012, sent the candidacy of Dr. Rita Leavell to USAID for approval. When approval was not received by March 1, Dr. Leavell gave notice that she had accepted another assignment. Headquarters staff immediately started a search for a new long-term international consultant. Salvatore Pappalardo's paperwork was submitted to USAID on March 22. He was initially disapproved by the COR because of his lack of health experience. However, the COR allowed IHBP to consider him in the short term while the local staff position was being recruited. A revised request for his approval was sent to USAID following the essential prerequisite of having a local staff person for leveraging hired.

In early 2012, IHBP recruited a local short-term consultant to help the international consultant work on strategy development. However, the local consultant approval request, which was submitted on February 24, was rejected by USAID.

6.3. Leveraging Advisor (IHBP Staff Position) Hired

In September 2012, IHBP successfully completed recruitment of Mr. Sanjeev Vyas, who will start work as IHBP's full-time Leveraging Advisor on October 8, 2012.

6.4. PSI Leveraging Activities – Generated US\$541,832 in 2011 for the Project

The Social Marketing Division of IHBP partner PSI procures contraceptives under the GOI's National Family Welfare Program. Under the social marketing program, condoms are made available to people at subsidized rates through social marketing organizations. Socially marketed condoms are marketed by various NGOs, which source the condoms at a highly subsidized rate from condom manufacturers contracted by MOHFW.

PSI bought 16.06 million condoms at a subsidized rate from the GOI and packaged and socially marketed the condoms in UP. The GOI procures the condoms at Rs. 1.54 per condom and sells to PSI at Rs. 0.40 per condom. The government subsidizes by Rs. 1.14 per condom. The total amount of subsidy from the government on the product is US\$398,147. PSI

generated program income of US\$143,685 and invested the same for distribution and marketing activities. The total amount of resources leveraged during FY 2011 was US\$541,832.

6.5. IHBP Leveraged Activities from GOI – Ongoing

IHBP leveraged US\$4,888 from NIHFWS while conducting two training programs for 58 ANMs in July 2012. In addition, IHBP leveraged mass media and print creative materials developed by the project for the FP and MH campaigns when MOHFW aired, printed, and distributed them. The exact amount of leveraging will be provided shortly.

V. International Short-Term Technical Assistance and Staff Travel Completed

Eight international STTA visits were completed during Year 2:

1. Andrea Arkin, Project Officer: November 4–23, 2011 (Delhi)
2. Sandra Wilcox, BCC Consultant: September 4–October 28, 2011 (Delhi)
3. Travel to Bangkok, Thailand, by the Deputy Chief of Party: February 8–10, 2012
4. Travel to Washington, DC, by Chief of Party Eleanora de Guzman: March 4–12, 2012
5. One MOHFW Official Sponsored to JHUCCP Course: June 3–22, 2012
6. Jill Randell, Project Director: April 9–25, 2012 (Delhi)
7. Orlando Hernandez, M&E Advisor: April 21–May 5, 2012 (Delhi)
8. Jill Randell, Project Director: August 21–September 7, 2012 (Delhi)

VI. Issues, Challenges, and Lessons Learned

As discussed in the previous IHBP Annual Report, the AED suspension and corresponding USAID CO instruction to delay major actions and the lack of a state took a heavy toll on IHBP start-up and implementation in Year 1. In Year 2, the project was able to launch and accelerate some activities at the national level. However, the continued lack of decision on a focus state and delayed decision on pilot districts postponed the launch of activities in pursuit of IRs 3 and 4, so crucial to IHBP's mandate. Additionally, delays in approval of major activities and plans by national government partners also hampered the pace of implementation. The following recapitulates specific issues and challenges faced by IHBP from October 2011 to September 2012.

1. Lack of USAID Approval of the IHBP Year 2 Work Plan, Lack of a State Focus and No Approval of Subcontractor Work Plans Resulted in Continued Poor Project Expenditures

More than half of the IHBP budget is allocated for the state and district levels (staffing, activities, and grants, among others). As a result of the lack of state-level activities, project expenditure levels continued to be low in Year 2. USAID did not grant formal approval of IHBP's Year 2 AWP and updated AMP and instructed IHBP, instead, to focus on national-level activities with government partners. Delays from MOHFW and NACO in approving specific activities in the POAs further delayed implementation. USAID instructed the project to delay approval of subcontractor Year 2 work plans, because most of their activities are related to the state or district level. IHBP has not approved these work plans as of the end of September 2012. PopCouncil and PSI are concerned that their part-time IHBP staff originally committed to work on the project are unable to work on IHBP activities; this has created coverage problems for them. No significant subcontractor activity was implemented in Year 2, beside staff seconded to IHBP, which further contributed to the low expenditure levels.

2. MOHFW Delayed Granting Approvals for Institution Strengthening Activities

Delays in gaining formal approvals by MOHFW held up institution strengthening activities. MOHFW agreed to these activities, notably, seconding consultants, ONA for MOHFW, capacity building activities with NIHFW, and establishing a BCC coordination mechanism, during meetings with USAID and IHBP. Minutes of these meetings, relevant SOWs, and TORs were formally sent to the government officials concerned. IHBP needs formal approvals since these activities require active government participation and ownership. In response to consistent IHBP follow-up, government counterparts informed the project that the files were moving. However, MOHFW approvals were granted only during the third quarter of Year 2, further delaying activity implementation. A letter from MOHFW endorsing IHBP support to NIHFW, as requested by IHBP during the first quarter of Year 1, was not issued. It was only after IHBP sent the official minutes of the February 27, 2012, meeting with Additional Secretary Desiraju that NIHFW consented, in May 2012, to collaboration with IHBP.

3. Turnover of MOHFW IEC Division JS Resulted in Delays

The turnover of the JS IEC position in MOHFW resulted in delays, because IHBP had to introduce the project, establish relationships, and initiate discussions with the new JS. IHBP was initially introduced to JS IEC Ms. Shankuntala Gamlin on April 29, 2011. Since that initial meeting, IHBP held several meetings with Ms. Gamlin on IHBP TA. Ms. Gamlin was very receptive to the proposal for an ONA and seconding BCC consultants. The concept of NIHFW as a Center of Excellence for BCC was based on Ms. Gamlin's idea for MOHFW to have a BCC resource center. Ms. Gamlin left her post in October 2011, and was replaced by a new JS, Mr. S.K. Rao. Mr. Rao assumed office in early 2012. IHBP went through the same project initiation process for Mr. Rao, who had his own ideas on what activities IHBP could support, thus resulting in some revision to IHBP's plans.

4. Delays Occurred in Setting Meetings with NACO Additional Secretary and Obtaining Approval of the NACO POA

In Year 2, USAID and IHBP continued efforts initiated in Year 1 to gain an appointment to introduce IHBP to the NACO Additional Secretary, Ms. Aradhna Johri, who agreed to a January 27, 2012, meeting. Immediately after this meeting, IHBP prepared its POA for NACO. This POA was submitted to NACO officially in February 2012. With the NACO Additional Secretary on medical leave, IHBP continued to hold discussions on the POA with NACO's IEC Joint Director and prepared specific documents for NACO review and approval (e.g., consultant SOWs, RFP for ad agency, concept paper for NHCRSC) so that activities could move forward. The NACO Joint Director advised the project not to initiate any action until formal approval is obtained from the NACO Additional Secretary. It was only on June 27, 2012, that IHBP was able to meet the Additional Secretary. During this meeting, the Additional Secretary granted general approval to the IHBP POA, but proposed some major changes, e.g., addition of consultants for NHCRSC, which needed further USAID approval. Thus, major actions under the NACO POA were further delayed.

5. Lack of a Decision on the State Hampered Procurement Actions

The RFPs for specific activities (ONA, scoping study for nodal organizations) were looking for proposals and budgets for the national level and one non-specific state, since IHBP could not cite UP, as per agreement with USAID. When these RFPs were issued at the end of Year 1, a strong possibility existed that a new state would be chosen by September or

October 2011. By mid-October 2011, no state had been named. IHBP focused activities at the national level and left the state activities for a second phase or another bidding process. Considering this, procurement actions were delayed, because IHBP requested shortlisted or winning agencies to revise their proposals and/or budgets accordingly, and negotiations had to be resumed, especially on the budgets.

6. Operating without an AWP and AMP Made Planning Very Difficult and Put IHBP at Risk

FHI 360 is concerned about being out of compliance, since the SOW of the approved task order and the current activities being implemented based on guidance from USAID are not the same. IHBP's AWP and updated AMP for Year 2 have never been approved and, as per COR verbal guidance, the project pursued activities in the POAs submitted to government partners—MOHFW's IEC Division and CTD and NACO. These POAs have also not been formally approved by the respective GOI agencies concerned. On February 10, 2012, FHI 360 sent a letter to the USAID CO seeking formal clarification on its SOW. This clarification has not been forthcoming despite follow-ups.

7. Lack of Approval of the July 2012–September 2013 Work Plan Further Delayed Grants Program

As discussed earlier, the COR gave approval to proceed with planning for July 2012–September 2013 activities. IHBP was able to submit this work plan, based on the POAs with MOHFW, NACO, and MOWCD, in July 2012. This work plan includes launch and implementation of the grants program to achieve IRs 3 and 4. IHBP set activities in motion to release RFPs for grants by October for launch of some grants in November 2012. However, at the request of USAID, further activity on the grants has slowed down.

8. Shift in IHBP Strategic Focus

Considering the changing scenario surrounding IHBP activities, the work plan for July 2012–September 2013 would have the following shifts in focus, which would change the deliverables as defined in the task order.

- **Increased focus on capacity building over institution strengthening.** In the original proposal and previous AWPs and AMPs submitted to USAID, institution strengthening was the core of the IHBP approach. The vision was to strengthen MOHFW's IEC Division and other program divisions for BCC first and, based on increasingly strengthened capacities, BCC activities at the national, state, and district levels (strategic planning, development of communication materials, mid-media, and IPC) would be implemented by the strengthened agencies with TA from IHBP. It has become increasingly clear that institution strengthening goals may not be achievable within IHBP's existing time frame. The more realistic goal is capacity building. However, this applies only to MOHFW, CTD, and MOWCD. NACO has categorically stated that capacity building of staff is not a priority, since the HIV/AIDS communication program is already in an advanced stage. Rather than capacity building and training, NACO needs tools to guide IEC officers in various aspects of BCC programming.
- **Increased focus on direct TA to national-level BCC campaigns.** IHBP identified direct TA in the development of BCC campaigns and communication materials as secondary to institution strengthening and capacity building. However, TA has gained increased importance in the POAs with various partners. Most of the assistance is in the form of support to the development of national, integrated BCC campaigns on health and HIV/AIDS and development of prototype materials for the national level.

- **More support for mass media.** The original project concept was for IHBP to provide minimal support to mass media activities and to increase support to mid-media and IPC. This was to offset the imbalance between government spending for IEC, which has had more allocations for mass media that served to increase awareness levels, but did not improve health practices. The POAs contain support for mass media materials development and media planning on a scale that was not originally envisioned. Nevertheless, IHBP will continue to support mid-media and IPC components in selected sites since these are key to changing practices targeted by mass media campaigns. MOHFW currently has minimal interest in rolling out the IPC and Community Mobilization components of the campaign. IHBP continues to advocate with MOHFW officials on the importance of these latter components.
- **Significantly reduced support to states and districts.** Considering the lack of a state focus and the thrust for assistance to national-level activities, IHBP support to states and districts has dramatically decreased. However, since IHBP continues to see the need for demonstrating the importance of mid-media and IPC to behavior change targeted by any mass media or multimedia campaign, the project will provide limited support to community mobilization and IPC activities in selected districts. These activities will be mainly anchored on national-level BCC campaigns that IHBP is supporting, specifically the FP and MH campaigns.
- **Revised evaluation strategy.** For Year 2, IHBP's AMP and concomitant evaluation strategy was revised. The original plan was to have a baseline and endline within the 3-year base period to determine changes in behaviors as a result of IHBP-supported but government-led interventions in the sites where IHBP would support mid-media and IPC. The national-level BCC campaigns that IHBP supports entail government implementation of mass media placements, production and distribution of materials, and corresponding training of health workers. Considering this, evaluation of IHBP influence on behavior changes due to these campaigns would be difficult, since IHBP has no control over implementation. For these campaigns, IHBP plans to conduct recall studies. Process documentation and monitoring would also assume greater importance. With the delay in launch of the grants program, the AMP would need to be further revised.

In Year 3, there is only a 12-month window of opportunity for IHBP to demonstrate results in behavior changes. This is quite short. The project team is ready to face the challenge, but needs the additional human resources, government buy-in, and donor support to succeed.

9. Difficulty Finding and Retaining SBCC Staff to Meet the Increased Demand for Campaign Development and TA

The project continues to face a challenge to identify staff and consultants with strong SBCC skills and experience in India, particularly in specific technical areas such as TB and HIV. While many development candidates have worked with communications activities, very few have sufficient technical training or experience to provide the strategic analysis and guidance for campaign development. These experts are highly sought after by other projects and donor agencies such as UNICEF. IHBP has faced continued issues with finding and retaining the expertise needed to meet the increased emphasis on campaign development for MOHFW and NACO. Supportive pairing with international experts or on-site TA has been and will continue to be necessary if more campaigns are required in Year 3.

In some cases, communications experts did not have the necessary technical background but did have the right communication skills. With the encouragement of USAID, IHBP has sought to pair such SBCC staff with medical and technical experts. Delays in approvals to

find the perfect skill set has sometimes resulted in losing the SBCC candidate and thus delays in project deliverables.

Finally, as IHBP has been requested to provide BCC consultants to NACO and to MOHFW, there will be increased need to orient and even train these seconded staff in the C-Planning process to ensure consistent messaging in TA. There will also be a need to not only fit consultant salaries to be at par with other seconded consultants, but also to hire and approve quickly and then retain these consultants once Year 3 (the official final year) is under way.