MCH SBCC MONOGRAPH

Ministry of Health
and Family Welfare
Government of India

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Social and Behavior Change Communication (SBCC) for Maternal and Child Health:
Good Practices from South Asia

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September 2013

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List of Acronyms

AFP	
AIIMS	All India Institute of Medical Sciences
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Center
AWW	Anganwadi Worker
BCC	Behavior change communication
BP	Birth preparedness
BP/CR	Birth preparedness/complication readiness
BPP	Birth preparedness package
BRAC	Bangladesh Rural Advancement Committee
CAG	Community action group
CBI	Community-based intervention
CB-MNC	Community-based maternal and neonatal care
CCA	Client-centered approach
CCB	Citizen community board
CDHM	Complete home diarrhea management
CEDPA	Centre for Development and Population Activities
CHS	Community Health Solutions
CHW	Community health worker
CLICS	Community-led Initiatives for Child Survival
CLTS	Community-led Total Sanitation
CMS	Commercial Marketing Strategies /Center for Media Studies
CVWS	Corporate Voice Weber Shandwick
CW	Community worker
DCM	Department of Community Medicine
DEO	District Education Office
DFID	United Kingdom Department for International Development
DoHFW	Department of Health and Family Welfare
DPHO	District Public Health Office
DWCD	Department of Women and Child Development
ECD	Early childhood development
EE	Entertainment–education
EmOC	Emergency obstetric care
EmONC-F	Emergency obstetric and neonatal care funds
EmONC-TS	Emergency obstetric and neonatal care transport systems
ENMC	Essential maternal and newborn care
EPI	Expanded Program on Immunization
FBC	Facility-based health committee
FCHVs	Female community health volunteers
FFC	Foundations for Change
FFL	Facts for Life
FOGSI	Federation of Obstetricians and Gynecologists Society of India
FP	Family Planning

FWA	Family welfare assistant
GGSS	Gali Gali Sim Sim
GOI	Government of India
GOP	Government of Pakistan
GTZ	German Technical Cooperation Agency
HMGN	His Majesty's Government of Nepal
HIS	Health services intervention
HUL	Hindustan Unilever, Ltd.
IAP	Indian Academy of Pediatrics
ICDDR	International Centre for Diarrhoeal Disease Research
ICDS	Integrated Child Development Scheme
ICT	Information Communication Technology
IEC	Information, education, and communication
IFA	Iron folic acid
IHBP	Improving Healthy Behaviors Program
IMNCI	Integrated management of neonatal and childhood illness
IMR	Infant mortality rate
IPC	Interpersonal communication
IPC/C	Interpersonal community and counseling
ISMPS	Indigenous system of medical practitioners
IVR	Interactive Voice Recording
JHU/CCP	John Hopkins University/Center for Communication Programs
JSY	Janani Suraksha Yojana
KAP	Knowledge, Attitudes, and Practices
KMC	Kangaroo Mother Care
KUSP	Kolkata Urban Sanitation Program
Kyunki	Kyunki Jeena Isi Ka Naam Hain
LAM	Lactational Amenorrhea Method
LBW	Low birth weight
LHV	Lady health volunteer
LHW	Lady health worker
MBPH	Market Based Partnership for Health
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MCHW	Maternal and child health workers
MCV	Mobile community viewing
MDGs	Millennium Development Goals
MEA	Muskaan ek Abhiyan
MIRA	Maternal and Infant Research Activities
MMR	Maternal mortality rate
MNCH	Maternal, newborn, and child health
MNH	Maternal and neonatal health
MoHFW	Ministry of Health and Family Welfare
MoHP	Ministry of Health and Population
MOMS	Monitoring of MNH Status
MoWCD	Ministry of Women and Child Development
NFE	Non-formal education
NFHP	Nepal Family Health Program

NFHS	National Family Health survey
NGOs	Nongovernmental organizations
NGP	Nirmal Gram Puraskar
NHEICC	Nepal Health Education, Information and Communication Centre
NIPHP	National Integrated Population and Health Program
NPSP	National Polio Surveillance Project
NSDP	NGO Service Delivery Partnership
NSMP	National Safer Motherhood Program
NRHM	National Rural Health Mission
NSMP	Nepal Safe Motherhood Program
ODF	Open defecation-free
OR	Operations research
ORS	Oral rehydration solution
PACT-CRH	Program for Advancement of Commercial Technology–Child and Reproductive Health
PAIMAN	Pakistan Initiative for Mothers and Newborns
PLHIV	People living with HIV
PNC	Postnatal care
POU	Point of Use
PPH	Postpartum hemorrhage
PRI	Panchayati Raj Institution
PSA	Public service announcement
PSI	Population Services International
PSP	Private Sector Partnerships
QTI	Quality improvement teams
RCH	Reproductive and child health
RH	Reproductive health
RHCC	Reproductive health coordination committee
RI	Routine immunization
RMNCH+A	Reproductive, maternal, neonatal, child health and adolescents
RMP	Rural medical practitioner
RSDP	Rural Service Delivery Partnership
SBA	Skilled birth attendant
SBCC	Social and behavior change communication
SBK	Saathi Bachpan Ke
SEC	Socio-economic class
SHG	Self help group
SIDA	Swedish International Development Agency
SM	Safe motherhood
SM/BP	Safe motherhood/birth preparedness
SMF	Safe motherhood forums
SMART	Safe Motherhood Applied Research and Training in Pakistan
SMNet	Social Mobilization Network
SNL	Saving Newborn Lives
SRS	Sample Registry System
SWI	Sesame Workshop India
TB	Tuberculosis
TBA	Traditional birth attendant
TNAI	Trained Nurses Association of India

TSC	Total Sanitation Campaign
U5MR	Under-5 mortality rate
UFHP	Urban Family Health Partnership
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
VCC	Village coordination committee
VDC	Village development committee
VHC	Village health committee
VHND	Village Health and Nutrition Days
VHSC	Village health and sanitation committee
VO	Village organization
WHO	World Health Organization
WRAI	White Ribbon Alliance of India

I. Executive Summary

India's infant and maternal mortality rates (MMR) are in consistent decline compared to previous decades. The Government of India (GOI) has implemented a wide array of programs, policies, and schemes to combat maternal and child health (MCH) challenges. Progress to mitigate poor health conditions and improve infant and maternal mortality health indicators by 2015 needs more effort and reshaping of outreach approaches, however.

FHI 360's Improving Healthy Behaviors Program (IHBP) is a USAID-funded project aimed at improving adoption of positive healthy behaviors in four technical areas: HIV/AIDS, family planning and reproductive health (FP/RH), tuberculosis (TB), and MCH. India—like other countries in the region and around the world—is striving to improve women's and children's health and wellbeing. IHBP conducted a literature review to identify good practices in social and behavior change communication (SBCC) for MCH in four major South Asian countries—India, Bangladesh, Nepal, and Pakistan—to inform MCH programming in India. SBCC is an interactive, theory-based, and research-driven communication process and strategy to address change at individual, community, and societal levels. SBCC is a process that uses a socio-ecological model for change and operates through three key strategies—advocacy, social mobilization, and behavior change communication (BCC).

Most of the 18 SBCC programs or interventions that met the criteria for inclusion in this document fit into three prevalent MCH intervention areas: maternal and neonatal health, safe motherhood/birth preparedness, and diarrhea prevention and focused primarily on BCC, although a few also employed advocacy and social mobilization strategies. Three categories of interventions emerged:

- **Programs that employed a "360-degree" approach:** These were large, comprehensive programs that aimed to increase demand for FP while improving the quality of provider services and/or increasing access to contraceptive methods. They used a mix of SBCC approaches and often relied on robust partnerships with NGOs and/or the private sector. These programs were successful in increasing contraceptive use; their approach involved using mutually reinforcing and complementary communication channels.

- **Programs that focused primarily on community-based initiatives:** These programs focused primarily on promoting FP at the community level through community media, community health workers/educators, or health care providers. Some utilized other SBCC strategies, but the bulk of their work utilized community-based channels.

- **Programs that focused primarily on mass media:** These programs focused primarily on mass media campaigns, either employing advertising or entertainment–education (EE) approaches. Some also had a community component, such as radio listening groups, but the main intervention was implemented through television or radio.

The case studies are organized to facilitate navigation through the document, not as a recommendation for how to focus an SBCC program. As discussed below, programs that employed a 360-degree approach were very effective. Those case studies that focused primarily on community-based initiatives or primarily on mass media also had good practices to offer. Each of these cases could have benefited from a wider mix of communication approaches.

Successful interventions reviewed employed at least two of the following "good practices":

- They rigorously followed the steps of a **communication planning cycle**, thereby employing a systematic approach for planning, implementation, and evaluation.
- They used a **"360-degree approach"** to increase demand for MCH services while providing high quality, accessible MCH services and products.
- They used **behavior change theories or models** to guide their program.
- They established a **strong, recognizable brand** for MCH products or services.
- They **segmented their target audiences** in ways that allowed activities to be tailored to people in different life stages or within very specific demographic categories.
- They not only targeted women, but also **MCH influencers**, including husbands, mothers-in-law, and sisters-in-law.
- They **adapted BCC materials to the local context** by translating them into multiple languages and utilizing locally available resources and technology.
- They provided **extensive training and support to health care providers** in facilities and/or at the community level. Support included robust supervision and high-quality job aids.
- They built **strong and innovative partnerships** with NGOs, community groups, government entities at local/district/national levels, local or national alliances and networks, health care/medical associations, commodities providers, or media groups.
- They linked **community activities with health services**, facilitating the mutual reinforcement of activities at both levels.
- They increased community support by utilizing **participatory processes** in the project design, implementation, or evaluation.
- They utilized **robust research** to drive the program, including formative research, pretesting, monitoring, and evaluation.
- They **focused on sustainability** by integrating interventions within government services, utilizing existing networks/systems, building the capacity of local NGOs, obtaining private sector support, and/or making their activities easy to scale up.
- They employed **high-quality media programming** and message design based on audience research and triggers most likely to provoke behavior change.

The findings of this review will inform the development of evidence-based SBCC strategies and programs to promote comprehensive MCH services in India.

II. Introduction and Methodology

A. Maternal and Child Health in India [1][2][3][4][5][6][7]

Infant and material deaths in India have declined in recent decades, but progress made thus far is not enough to meet the targets for Millennium Development Goals (MDGs) 4 and 5—reduce by two-thirds the under-5 mortality rate and reduce by three-quarters the maternal mortality ratio (MMR) between 1990 and 2015. The GOI has implemented a wide array of programs, policies, and various schemes to combat MCH challenges, but progress to mitigate poor health conditions and improve infant and maternal mortality health indicators by 2015 needs more effort and reshaping of outreach approaches.

With a current IMR of 43.19 deaths/1,000 live births (2014 estimate) and under-5 mortality rate (U5MR) of 56 out of 1,000 live births (2012 estimate), India is unlikely to reduce by two-thirds the under-5 mortality rate by 2015. India also continues to contribute about a quarter of all global maternal deaths. However, there is steady progress to reduce the MMR as evidenced by the 2010 MMR estimate of 200 per 100,000 live births. This is a decline from earlier ratios of 254 and 301 per 100,000 live births, according to Sample Registration System (SRS) Reports for 2004–2006 and 2001–2003, respectively. The Ministry of Women and Child Development (MoWCD) and Ministry of Health and Family welfare (MoHFW) are taking the lead and making strides in providing comprehensive services to create an environment in which all women, newborns, children, and adolescents not only are healthy but thrive.

Throughout the years, India has undertaken many programs focused on MCH, attacking the issues from multiple angles, including rural development, sanitation, and nutrition. India's MCH activities were initiated in the early 1900s when maternity services were improved. MCH programs were introduced in the early 1950s and intensified in 1952–54 under the GOI National Extension Program for rural areas, later called Community Development Program. Various specific programs for mothers and children were introduced or expanded through the following decades. In 1973, the workers of different vertical programs were converted into multi-purpose workers. Originally introduced in 1978, oral rehydration therapy became a full-fledged national program in 1986. The Reproductive and Child Health (RCH) Program launched in 1997, integrated services promoting safe motherhood (SM), national family welfare and child survival, with family planning (FP) and the prevention and management of sexually transmitted diseases. In 2002, the GOI introduced the Integrated Management of Neonatal and Childhood Illnesses Program (IMNCI), which falls under child health in the RCH Program.

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[1] NIMS, ICMR and UNICEF, 2012*, Infant and Child Mortality in India: Levels, Trends and Determinants*, National Institute of Medical Statistics (NIMS), Indian Council of Medical Research (ICMR), and UNICEF India Country Office, New Delhi, India.

[2] Singh, S. Maternal and Child health services in India – past, present and future. National Center for Biotechnology Information, 1997. www.ncbi.nlm.nih.gov/pubmed/12348092.

[3] Overview of Maternal and Child Health. UNICEF. www.unicef.org/india/overview_4457.htm7

[4] Raj SS, Maine D, Sahoo PK, Manthri S, Chauhan K. Meeting the community halfway to reduce maternal deaths? Evidence from a community-based maternal death review in Uttar Pradesh, India. Glob Health Sci Pract. 2013;1(1):84-96. http://dx.doi.org/10.9745/GHSP-D-12-00049

[5] http://www.nytimes.com/2013/11/08/opinion/child-mortality-in-india.html?_r=0

[6] Central Intelligence Agency (CIA) World Factbook. www.cia.gov/library/publications/the-world-factbook/geos/in.html

[7] Child Mortality Estimates (CME). UNICEF, UNPD, WHO, and World Bank. www.childmortality.org/index.php?r=site/graph#ID=IND_India

Despite the slow progress to achieve MDGs 4 and 5 by 2015, GOI continues to make intensive efforts to improve child health and strengthen maternal health care facilities under the RCH program and the National Rural Health Mission (NRHM). Emphasis is geared toward ramping up demand to increase utilization of the different services offered by reaching out to the unreached populations and ensuring uniform distribution of resources.

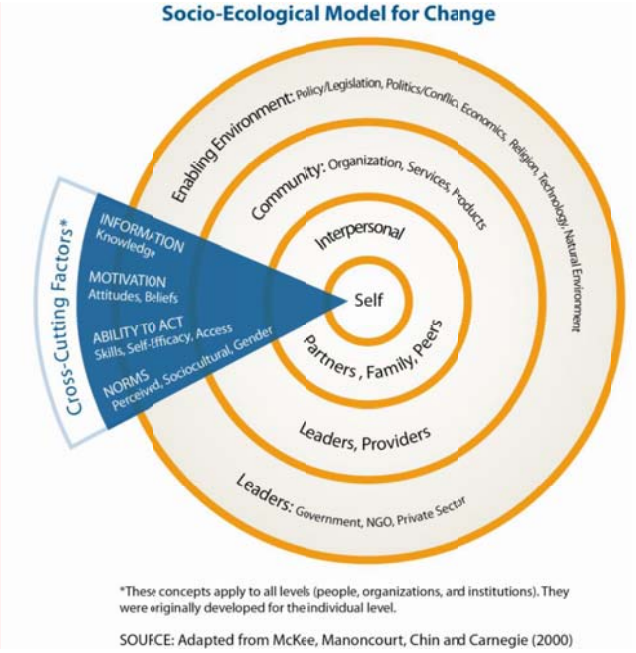
B. Improving Healthy Behaviors Program (IHBP)

The FHI 360 USAID/India-funded Task Order for IHBP aims to improve the adoption of healthy behaviors through institutional and human resource capacity building of national-, state-, and district-level institutions to design, deliver and evaluate communication programs that will:

- Increase knowledge and change attitudes and behaviors of individuals, families, communities, and health providers about health.
- Promote an environment where communities and key influencers support positive health behaviors.
- Reduce barriers of vulnerable populations (for example, women, people living with HIV or PLHIV, TB patients) to demand and access health services.

The project focuses on four technical areas: HIV/AIDS, FP/RH, tuberculosis, and MCH.

C. Overview of Social and Behavior Change Communication (SBCC)



SBCC is an interactive, theory-based, and researched-driven communication process and strategy to address change at individual, community, and societal levels.[8] It is a process that uses a socio-ecological model for change, and operates through three strategies:

- **Advocacy** to raise resources and political/social leadership commitment for development actions and goals

- **Social mobilization** for wider participation, coalition building, and ownership, including community mobilization

- **Behavior change communication (BCC)** for changes in knowledge, attitudes, and practices of specific participants/audiences in programs

SBCC applies a socio-ecological model[9] that examines several levels of influence to provide insight on the causes of problems and to find the ***tipping point*** for change—the point at which a behavioral practice spreads suddenly within and across

[8] C-Modules. A Learning Package for Social and Behavior Change Communication. Module 0 Practitioner's Handbook.
[9] Ibid.

populations.[10] This model is a combination of ecological models and sociological and psychological factors and layers of influence that can assist program managers in analysis and planning.

Effective SBCC programs are based on the following principles:[11]

- **Principle #1:** Follow a systematic approach.
- **Principle #2:** Use research (e.g., operational) not assumptions, to drive programs.
- **Principle #3:** Consider the social context.
- **Principle #4:** Keep the focus on the key audience(s)/population(s).
- **Principle #5:** Use theories and models to guide decisions.
- **Principle #6:** Involve partners and communities throughout.
- **Principle #7:** Set realistic objectives and consider cost effectiveness.
- **Principle #8:** Use mutually reinforcing materials and activities at many levels.
- **Principle #9:** Choose strategies that are motivational and action-oriented.
- **Principle #10:** Ensure quality at every step.

These principles can serve as a compass, helping managers and SBCC specialists to plan their programs and stay on track during implementation and evaluation. Many of the good practices described in this document tie into the 10 principles outlined above.

D. Purpose of Document and Methodology

IHBP commissioned a review of good practices in SBCC for MCH to help SBCC specialists and program managers design and implement effective communication programs. The authors reviewed published and unpublished literature to identify successful SBCC interventions in India and neighboring South Asian countries—Nepal, Bangladesh, and Pakistan. Documents that describe these interventions were accessed via Internet search engines, academic databases, public health clearinghouses, and the websites of donors and implementing organizations. In addition, the researchers used their networks to access documents not available online.

About 70 case studies were identified through the initial search. Based on a review of existing literature about good or best practices, the following criteria were used to assess a program as employing "good practices":

1. The intervention had a clear and documented strategy for communication and was founded on some clear principles or theories/frameworks for strategic communication.
2. The intervention addressed both demand generation as well as the provision of relevant, accessible, and quality services and products. In the latter case, this does not imply direct provision but rather the strengthening of existing services and products.
3. The intervention was based on principles of community participation/involvement, integration with government systems, and/or partnerships with the private sector.
4. The intervention had the potential for scale up, replication, and sustainability.

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[10] Ward, T. et al. Leadership and Communication: Lessons from The Tipping Point. Cambridge Center for Behavioral Studies, Inc. 2011. Downloaded at http://www.behavior.org/resources/503.pdf.

[11] C-Modules. A Learning Package for Social and Behavior Change Communication. Module 0 Practitioner's Handbook.

A total of 18 programs or interventions met these criteria. Most of them focused on BCC, although a few also employed advocacy and social mobilization strategies.

The section below describes the good SBCC practices that were identified, with examples from selected case studies. The summary of good practices is followed by a matrix of case studies. Not all of the case studies will be relevant for all readers. ***Therefore, readers are invited to consult this matrix to identify the case studies that most closely match their own programs, and then read those specific case studies to obtain detailed information about how these programs used good SBCC practices.*** An index at the end of this document cross references all case studies by good practices, for those readers who wish to consult those program examples that effectively demonstrate a particular good practice.

III. Good Practices and Case Studies

As mentioned in the prior section, SBCC operates through three key strategies—advocacy, social mobilization, and BCC. The SBCC interventions identified through this review focused primarily on BCC, although some also employed advocacy and social mobilization strategies.

A. Good Practices

A wide range of good practices were identified in program design, implementation, and evaluation. Interventions that met the criteria for inclusion in this document employed at least two of the following good practices:

- They rigorously followed steps of a **communication planning cycle**, thereby employing a systematic approach for planning, implementation, and evaluation. Smiling Sun Bangladesh developed an implementation plan that covered preparatory activities, development, and production of campaign support materials as well as manuals, templates, and guidebooks. In the National Safer Motherhood Program (NSMP) in Nepal, district-level communication plans/programs were developed based on the National Information, Education, and Communication (IEC) Strategy (2002–2007) and then implemented through local partners.

- They used a **"360-degree approach,"** using mutually reinforcing materials and communication channels at many levels to increase demand for MCH services while providing high-quality, accessible, and affordable MCH services and products. Sure Start India used a variety of community-based activities, complemented by capacity building of female private providers, advocacy with all levels of government, journalists, and religious leaders and supported by a variety of mass media programming. The PAIMAN project in Pakistan combined mass media such as TV, radio, and public service announcements (PSAs) with building the capacity of service providers and the formation of village health committees, citizen community boards, and other groups that would deliver messages and other information through a variety of channels.

- They used **behavior change theories or models**[12] to guide their programs. The marriage of theory with practice is critical for enhancing the effectiveness of an intervention. SUMATA in Nepal based its work on the Stages of Change Theory (Prochaska), which focuses on an individual's readiness to change a problem behavior and the stages that she or he goes through in attempting the behavior change. This theory facilitated the development of an integrated SBCC strategy and an advocacy strategy, which served as guides to implement the program. Sesame Workshop India used Social Learning Theory (Bandura), which focuses on how people learn by observing the actions of others and the benefits of those actions, as their approach to promoting behavior and social change.

- They established a **strong, recognizable brand** for MCH services or products. Bangladesh's Smiling Sun project implemented a highly- campaign, brand name, and logo recognized by

[12] Theory at a Glance: A Guide for Health Promotion Practice (Second Edition). National Cancer Institute. U.S. Department of Health and Human Services. 2005.

almost two-thirds of respondents, and the majority could name specific MCH services available in their area. The "service with a smile" slogan was designed to reinforce the brand name/logo.

- They **segmented their target audiences** in very detailed ways that allowed activities to be tailored to people in different life stages or within very specific demographic categories. This included the Sure Start program in India, which provided messages to women depending on which trimester of pregnancy they were in. POUZN targeted activities to rural and urban poor.

Sure Start – India

The Sure Start project employed a 360-degree approach building on community engagement combined with provision of services and mass media to enhance maternal and neonatal health through relatively simple acts and take advantage of health services when they are available. The project was created to help families in crowded urban slums and in rural areas understand the steps they can take to help their babies survive and thrive. The target audience was pregnant women and women of child-bearing age, as well as health care providers in urban Maharashtra and rural Uttar Pradesh (UP). Sure Start used a needs-based, finely tailored BCC approach rather than generic "one-size-fits-all" messages so that information was relevant and useful to the very specific needs of individual women. A key to Sure Start's success was integration with government entities to facilitate implementing to scale. The project employed high quality media through innovative and creative campaigns, such as Pehla Ek Ghanta, which increased momentum and buzz, and mobilized diverse stakeholders. Sure Start also combined demand-generation with enhanced access to quality health services through mothers' groups and village health and sanitation committees (VHSCs) and community insurance, as well as monitoring committees. Highlights of the project include a significant increase in the number of pregnant women in urban Maharashtra who receive prenatal care, twice as many women who give birth in health facilities, and enhanced community engagement that gives people the power to save their own lives.

- They not only segmented and targeted women, but also **MCH influencers,** including husbands, mothers-in-law, and sisters-in-law. This allowed the programs to address broader issues that influence MCH, such as FP or men's or family members' roles in making sure women access care. Examples of this included the *Kyunki Jeena Isi Ka Naam Hai* television program, which aimed to reach husbands and other family members using an EE format, and Pakistan PAIMAN program's music video, which emphasized male responsibility in pregnancy and childbirth. Nepal's NSMP worked not only with mother's groups but also within mother-in-law/ daughter-in-law gatherings to discuss and question traditionally accepted but harmful behaviors and practices.

- They **adapted BCC materials to the local context** by translating them into multiple languages and by utilizing locally available resources or technology. This was accomplished by POUZN India, which developed a range of simple, focused materials, including home testing kits that showed how contaminated people's water was and village "haats" or market-based activities. Nepal's Women's Health Groups in Perinatal Health enlisted community women's groups in adapting birth/delivery kits based on local materials, with profits going to a mother and child fund, as well as developing different materials focused on the local context: storytelling, a film, and hand-held cards of different shapes.

- They provided **extensive training and support to health care providers** in facilities and/or at the community level. Support included robust supervision and high-quality job aids, as in India's

Muskaan Ek Abhiyan, which trained all health workers and provided incentives based on performance. Pakistan's Safe Motherhood Applied Research and Training in Pakistan (SMART) program trained female health workers, doctors in private practice, and public health managers in client-centered health service provision, leadership, and supervision.

- They built **strong and innovative partnerships** with NGOs, community groups, government entities at the local, district, and national levels; local or national alliances and networks; health care and medical associations; commodities providers; or media groups. India's Saathi Bachpan Ke program for home-based diarrhea treatment reached general practitioners and pediatricians through the Indian Academy of Pediatrics (IAP) to prescribe and recommend oral rehydration solution (ORS) for children. The POUZN program in India worked with suppliers of point-of-use (POU) water treatment products and commercial filter manufacturers to ensure that POU products to decontaminate water were available to the community at a cost-effective price.

- They linked **community activities with health services**, facilitating the mutual reinforcement of activities at both levels. As part of Saving Newborn Lives (Projahnmo/Mamoni) in Bangladesh, the interpersonal communication (IPC) outreach strategy and community group activities were complemented by strengthening systems and quality of care at more than 275 public health facilities in Habiganj. The SMART program in Pakistan built a link between *dais* (rural Pakistani women who earn their living through midwifery) and female health workers, and between *dais* and health facilities and established emergency obstetric and neonatal care funds and transport systems, which decreased delays in urgent care-seeking.

- They increased community support by utilizing **participatory processes** in the project design, implementation, or evaluation. This was exemplified by the Community-Led Total Sanitation (CLTS) program in Kalyani in India; the participatory nature of the program helped participants see and experience for themselves the consequences of poor sanitation and triggered action. In India's Community-Led Initiatives for Child Survival (CLICS), members of the village coordination committees (VCC) and other stakeholders were kept informed about the progress on planning health activities and were invited to provide their input for improved outcomes. Moreover, making the VCC responsible for mobilizing and managing funds led to greater self-reliance and accountability.

- They utilized **robust research** to drive the program, including formative research, pretesting, monitoring and evaluation. Bangladesh's Manoshi project pretested all materials to ensure that they were culturally sensitive and clear. Based on feedback from pretesting, the program redesigned visuals that previously embarrassed the families (because they were physically explicit) to visuals that were less provocative. India's Kyunki Jeena Isis Ka Naam Hain used varied research approaches to track and improve the program, for example, by repeating messages and simplifying music and lyrics of the songs to make them easier to understand and hum. The Saathi Bachpan Ke (SBK) program in India used consumer/market research to develop, test, and monitor all key interventions, creative advertising items, merchandising, training, retailing, and contact programs, and to track knowledge and attitudes among providers and track ORS sales.

- They **focused on sustainability** by integrating interventions within government services, utilizing existing networks/systems, building the capacity of local NGOs, obtaining private sector support,

and/or making their activities easy to scale up. In the MaMoni project in Bangladesh, sustainability of the program was secured by intensive involvement of the community through mechanisms such as community action cycles, community clinic management groups, and community action groups. The India's Community-Led Total Sanitation (CLTS) program, for example, focused on changes that would be sustainable, such as investing in community mobilization instead of hardware, and shifting the focus from toilet construction for individual households to the creation of "open defecation-free (ODF) neighborhoods."

- They employed **high-quality media programming** and message design based on audience research and triggers most likely to provoke behavior change. India's Sure Start used innovative and creative campaigns, such as Pehla Ek Ghanta, which increased momentum and buzz, and mobilized diverse stakeholders. Sesame Workshop India involved high-quality professional programming content and production values were equal to commercial program quality.

B. Innovations

The review highlighted several examples of practices that were innovative at the time when these interventions were implemented. For example:

- **Using private sector practices such as change management and demand creation and applying them to development programs.** Sure Start linked demand generation approaches with support from mothers' groups and village health services committees. And in Nepal, the Safer Motherhood Project used change management to transition the project from small scale to larger scale (see text box below).

Nepal Safer Motherhood Program

Public health services in Nepal are still constrained by resource and staff shortages, especially in rural areas. The difficult terrain further creates uneven coverage patterns. The Nepal Safer Motherhood Program (NSMP) was created to reduce maternal mortality by increasing utilization of and access to quality emergency obstetric care (EmOC). NSMP employed innovative approaches such as change management—more typical of the corporate sector—to health services. This approach helped deliver positive changes in attitudes, behaviors, and working practices that strengthened organizational/institutional development. Key to the success of the project was a genuine commitment to fostering local ownership and participatory approaches to problem solving. The program improved the performance of technical and managerial personnel, as well as enhancing their morale, motivation, and pride. It increased access to services through BCC (radio, street drama, print materials) and addressed practical issues such as emergency transportation and funding schemes. It also addressed poor availability, perception of, and utilization of health services. The program yielded a 2 percent average annual increase in met need for EmOC in 11 districts and safe motherhood was mainstreamed into other health activities. Hospitals experienced improved leadership, a congenial atmosphere, and performance-based incentives. Intra-family communications improved and mothers-in-law and husbands provided more support for pregnant and newly delivered women in their family. Overall, there was improved quality of services, record keeping, and relations with the community.

- **Using information and communication technology (ICT) to improve the quality of care**. For example, in the Manoshi program health workers collected patient information on their mobile phones and sent it to doctors, who were then able to provide feedback/advice on antenatal and

postnatal care remotely. Sesame Workshop India also used ICT, employing video-based training modules and a telephone-based support system for frontline workers (see text box below).

- **Using customized interpersonal communication (IPC) to address the specific needs of the target audience.** This includes factoring in the different languages and cultural contexts of the population. For instance, in the Sure Start project in urban Maharashtra, providers gave plastic tiffin boxes to the pregnant woman so that she could set aside food for herself, a birth preparation calendar, and a piggy bank for savings to ensure individual women (at the household level) were prepared. In rural Uttar Pradesh, the Sure Start project increased male participation in reproductive health through "letters from the unborn child" to the prospective father.

Sesame Workshop India – Using Entertainment–Education (EE) for Health and Hygiene

The Sesame Workshop India (SWI) uses television, community events and school events to enhance early childhood development. Recognizing the importance of interactive and ongoing capacity-building, SWI moved to video-based training modules and introduced phone-based support systems to facilitate regular technical support to frontline workers. The short video-based training modules provided specific action points for the anganwadi workers (AWW), such as how to make storytelling more effective. A curriculum integration document outlined the activities to be conducted by the AWW each day of the week. The telephone-based support system had three components:

- **A call to the AWWs:** Weekly activities were recorded and uploaded on the server.
- **Feedback:** The caller had the option of leaving feedback on this system. The SWI team returned the phone calls to respond to the feedback.
- **Poll:** The system conducted polls to understand overall user response to the materials/support provided and collect votes for favorite components/activities. This facilitated quality improvement and assurance.

C. Case Studies

The following table summarizes the programs and interventions that met the criteria for inclusion in this document. They are organized into to three categories based on MCH intervention areas:

- **Maternal and Neonatal Health** – This included antenatal and postnatal care for mothers (for example, regular health care examinations/visits during pregnancy, immunization, awareness of danger signs), and neonatal care for infants (such as, cord care, thermal care of the newborn, immediate and exclusive breastfeeding, immunization).

- **Safe Motherhood/Birth Preparedness (SM/BP)** – This included awareness of and use of skilled birth attendants, increased use of birthing facilities, and awareness of and access to EmOC in the case of complications, all to reduce the risk of significant injury or death to the mother. Case studies in this category also addressed the issue of gender equity, and ensuring that women could participate in decisions related to their pregnancies and birth of their children.

- **Diarrhea Prevention** – This included programs to increase the use of ORS, zinc, and water treatment methods and products, as well as to improve sanitation practices to prevent childhood diarrhea.

Within each MCH intervention area, the case studies are organized by programs that employ the following approaches:

- **Programs that employed a "360" approach:** These were large, comprehensive programs that aimed to enhance MCH services, encourage the use of clinics and health facilities, increase access to and demand for safe motherhood, increase awareness, and promote positive MCH health behaviors. They used a mix of SBCC approaches and often relied on robust partnerships with nongovernmental organizations (NGOs) and/or the private sector. These types of programs approached the MCH issue from multiple, complementary angles.

- **Programs that focused primarily on community-based initiatives:** These programs focused primarily on promoting MCH at the community level, through community media, community health workers and educators, or health care providers. Some utilized other SBCC approaches, but the bulk of their work was at the community level.

- **Programs that focused primarily on mass media:** These programs focused primarily on mass media campaigns through EE approaches. One of the two reviewed programs had a community component to enhance early childhood development (ECD) by working with and through children under 9 years to reach the community at large, but the main intervention for both programs was implemented through television.

The case studies are organized to facilitate navigation through the document, not as a recommendation for how to focus an SBCC program. As discussed earlier, programs that employed a 360-degree approach were very effective. Those case studies that focused primarily on community-based initiatives or primarily on mass media also had good practices to offer, although they could have benefited from a wider mix of communication approaches.

In each category, the case studies are organized by country—India first, followed by examples from Bangladesh, Nepal, and Pakistan. The following are some definitions of key terms used in the matrix:

- ***Mass media =*** Radio (talk shows, PSAs, audio dramas), television (soap operas, PSAs, talk shows, films), and print (magazine, newspaper) used to deliver messages to large sections of people.

- ***Provider interpersonal communication and counseling (IPC/C) =*** IPC/C provided individually or in groups through health facilities or providers to build trust, open-up dialogue, facilitate the exchange of perceptions, opinions, and knowledge, and support the empowerment of individuals.

- ***Community IPC/C and mid-media =*** IPC/C provided individually or in groups by community health volunteers or community change agents using local, sometimes traditional forms of communication that is interactive and entertaining such as puppet shows, drama, street theater, music, and games to deliver messages to the community and create awareness. Mid-media is usually used in media dark areas and helps to build environment around an issue.

- ***Advocacy*** = Activities to directly or indirectly influence decision makers, the public opinion and/or relevant audiences to support and implement specific policies or actions.

Maternal and Child Health Case Studies

Name and Location	SBCC Channels	Objectives	Target Audiences	Good Practices
PROGRAMS ADDRESSING MATERNAL AND NEONATAL HEALTH				
PROGRAMS EMPLOYING A 360 DEGREE APPROACH				
1. Sure Start India (Rural Uttar Pradesh and Urban Maharasthtra)	• Mass media • Provider IPC/C • Community IPC/C/mid-media • Advocacy	• Enhance maternal and neonatal health, with specific objectives to increase institutional delivery and positive newborn practices	• Pregnant women and women of child-bearing age • Health care providers	• 360 approach • Detailed audience segmentation • Focus on sustainability • High-quality media programming • Strong/innovative partnerships • Targeting of MCH influencers
2. Smiling Sun Bangladesh	• Mass media • Provider IPC/C • Community IPC/C/mid-media	• Encourage the use of clinics/facilities to obtain MCH services and products	• Families, pregnant women and mothers	• 360 approach • Communication planning cycle • Extensive provider training/support • Strong product/service branding
3. Pakistan Initiative for Mothers and Newborns (PAIMAN) Pakistan (24 districts, 2 Frontier Regions, and FATAs)	• Mass media • Provider IPC/C • Community IPC/C/mid-media • Advocacy	• Increase awareness and promote positive MNH behaviors • Increase access and community involvement in MCH services • Improve service quality in the public and private sectors, particularly with management of obstetrical complications • Increase capacity of MNH managers and care providers • Build the capacity of community-based religious decision makers and engage them to advocate to men on behalf of MNCH issues in their sermons and lectures	• Married women of reproductive age • Key religious decision makers in the community to engage men	• 360 approach • Focus on sustainability • Strong/innovative partnerships • Targeting of MCH influencers
4. Manoshi Bangladesh (Urban slums of 6 city corporations and 15 metropolitan areas of Dhaka)	• Mass media • Provider IPC/C • Community IPC/C/mid-media	• Develop a community-based health package to tackle maternal, newborn, and child illnesses in urban slum populations	• Pregnant and lactating women, neonates, children • Newly married couples	• 360 approach • Participatory processes • Robust research

Name and Location	SBCC Channels	Objectives	Target Audiences	Good Practices
PROGRAMS FOCUSED PRIMARILY ON COMMUNITY-BASED INTERVENTIONS				
5. Community Led Initiatives for Child Survival (CLICS) India (67 villages in Wardha district, Gujarat)	• Community IPC/C/mid-media	• Create a sustainable health care system at village level for improving the health status and wellbeing of children under 3 and women of reproductive age through affordable, high-quality care with effective partnerships at the community level • Create awareness about preventive health practices for promoting behavior change	• Women, mothers/ caregivers of children under 3 • Women's self-help groups • Village groups and other community-based organizations and their members	• Focus on sustainability • Participatory processes • Strong/innovative partnerships
6. Muskaan Ek Abhiyan (The Smile Campaign) India (Bihar)	• Provider IPC/C • Community IPC/C/mid-media	• Achieve 100% immunization of infants and pregnant women in Bihar, India	• Pregnant women and mothers of young children • Community groups	• Extensive provider training/support • Strong/innovative partnerships
7. Saving Newborn Lives (Projahnmo/MaMoni) Bangladesh (Sylhet District)	• Provider IPC/C • Community IPC/C/mid-media	• Increase healthy maternal and newborn practices, including training for health workers to improve basic services; improving neonatal care; and promoting family planning	• Pregnant women, mothers, women immediately postpartum • Husbands, mothers in law	• Extensive provider training/support • Focus on sustainability • Strong community–health services linkages
8. Women's Health Groups in Perinatal Health Nepal (Makwanpur District)	• Community IPC/C/mid-media	• Improve maternal and newborn care in rural Nepal, and reduce perinatal and neonatal mortality.	• Women's groups (including pregnant women and mothers)	• Adaptation of materials to local context • Participatory processes
PROGRAMS FOCUSED PRIMARLIY ON MASS MEDIA				
9. Kyunki Jeena Isi Ka Naam Hai India (National with focus states: UP, Madhya Pradesh, Jharkhand, Rajasthan, Bihar, and Chattisgarh)	• Mass media	• Adapting *Facts for Life* information on MCH into an entertainment format to improve MCH.	• Women and other caregivers, women in 15–35 age group, husbands, family elders in low income groups • Frontline workers and influencers	• Focus on sustainability • High-quality media programming • Robust research

Name and Location	SBCC Channels	Objectives	Target Audiences	Good Practices
PROGRAMS ADDRESSING SAFE MOTHERHOOD/BIRTH PREPAREDNESS				
PROGRAMS EMPLOYING A 360 DEGREE APPROACH				
10. SUMATA Initiative Nepal (Banglung, Lalitpur, and Kailali)	• Mass media • Community IPC/C/mid-media • Advocacy	• Increase access to and demand for safe motherhood through a focused and coordinated policy environment • Improved quality of maternal and newborn health services; and • Adoption of appropriate maternal and newborn health behaviors	• Women, husbands, families, community leaders, and community-based health workers in rural areas	• 360 approach • Strong/innovative partnerships • Theory/model as foundation
11. Nepal Safer Motherhood Program (NSMP) Nepal (13 districts)	• Mass media • Provider IPC/C • Community IPC/C/mid-media • Advocacy	• Reduce maternal mortality by increasing utilization and access to quality emergency obstetric care	• Obstetric services providers • Pregnant women and recently delivered mothers • Government stakeholders	• 360 approach • Communication planning cycle • Extensive provider training/support • Focus on sustainability
PROGRAMS FOCUSED PRIMARILY ON COMMUNITY-BASED INTERVENTIONS				
12. Advocacy for Safe Motherhood India (National with 6 focus states)	• Advocacy • Community IPC/C/mid-media	• Raise awareness of the need to ensure safe pregnancy and childbirth • Increase accountability for safe motherhood	• Governments, NGOs, citizens, especially women of child-bearing age and their families	• Focus on sustainability • Strong/innovative partnerships
13. The Birth Preparedness Package (BPP) Nepal (Banke, Jhapa, and Kanchanpur districts)	• Provider IPC/C • Community IPC/C/mid-media	• Improve the health and survival of mothers and newborns by improving knowledge and practices related to MNH services • Promote active preparation and decision-making for births by pregnant women and their families	• Pregnant women and their families • Community members	• Extensive provider training/support • Focus on sustainability
14. Safe Motherhood Applied Research and Training (SMART) Pakistan (Dera Ghazi Khan and Layyah districts)	• Provider IPC/C • Community IPC/C/mid-media	• Reduce the delays in getting medical care in the face of obstetric complications	• Community members (women of child-bearing age and their families) • Health care providers at the facility level	• Adaptation of materials to local context • Extensive provider training/support • Strong community–health services linkages

Name and Location	SBCC Channels	Objectives	Target Audiences	Good Practices
PROGRAMS ADDRESSING DIARRHEA PREVENTION (ORS, POU Water Disinfection, Sanitation)				
PROGRAMS EMPLOYING A 360 DEGREE APPROACH				
15. Saathi Bachpan Ke (SBK) India (Urban areas of 8 Hindi belt states: UP, Madhya Pradesh, Rajasthan, Bihar, Dehli, Jharkhand, Uttarakhand, and Chhattisgarh)	• Mass media • Provider IPC/C • Community IPC/C/mid-media • Advocacy	• To increase the market for ORS as a first-line treatment for childhood diarrhea	• Caregivers, mothers, fathers, households with children up to the age of 5 • Health care providers • Pharmacists/chemists	• 360 approach • Focus on sustainability • High-quality media programming • Robust research • Strong/innovative partnerships
PROGRAMS FOCUSED PRIMARILY ON COMMUNITY-BASED INTERVENTIONS				
16. POUZN Project India (UP, Kanpur, Lucknow and Allahabad cities, and villages of Basti, Faizabad, Ambedkar Nagar, and Sultanpur)	• Provider IPC/C • Community IPC/C/mid-media	• Encourage home-based management of diarrhea using ORS and zinc treatment • Increase the use of POU methods by promoting awareness, acceptance, availability, and affordability	• Households in urban and rural poor communities	• Adaptation of materials to local context • Detailed audience segmentation • Focus on sustainability • Strong/innovative partnerships
17. Community-Led Total Sanitation (CLTS) India (Slums of Kalyani township)	• Community IPC/C/mid-media	• To create an "open defecation-free" township and improve the sanitation and health of the community overall	• Council members • Community based organizations • Community members/ heads of household	• Focus on sustainability • Participatory processes • Theory/model as foundation
PROGRAMS FOCUSED PRIMARILY ON MASS MEDIA				
18. Sesame Workshop India (SWI) India	• Mass media • Community IPC/C/mid-media	• Targeting children to improve health, hygiene, hand washing and nutrition	• Children • Partners, teachers, other caregivers, including anganwadi workers	• Extensive provider training/support • High-quality media programming • Robust research • Theory/model as foundation

A. Programs Addressing Maternal and Neonatal Care

The following case studies provide detailed descriptions of the programs and operations research (OR) studies summarized in the matrix above. They are presented in the same order as in the matrix, starting with programs that employed a "360" approach, followed by programs focusing primarily on community-based approaches and programs focused primarily on mass media interventions. Additional information can be found by consulting the publications and sources for each case study, many of which can be found online.

Programs Employing a "360" Approach

1. Sure Start	
Donor: Bill & Melinda Gates Foundation **Implementing agency:** 95 partner NGOs; government agencies at the village, block, and district levels; and technical assistance from PATH	**Good Practices:** • 360 approach • Detailed audience segmentation • Focus on sustainability • High-quality media programming • Strong/innovative partnerships • Targeting of MCH influencers
Duration: 2006–2011 **Geography:** Rural Uttar Pradesh: 12,000 villages across eight districts (Bahraich, Hardoi, Lucknow, Barabanki, Rae Bareli, Basti, Balrampur, and Gorakhpur). Urban Maharashtra: Seven cities (Malegaon, Greater Mumbai, Mumbai, Navi Mumbai, Pune, Solapur, Nanded, and Nagpur).	
Publication/Source: 1. Evaluation of the Sure Start Project in Uttar Pradesh: Key Findings and Recommendations. PATH. Seattle, PATH February 2013. 2. Innovative BCC for Improved Maternal & Neonatal Health – Sure Start Project, India (PowerPoint Presentation). Shankar, S. 3. Pehla Ek Ghanta – Sure Start Campaign for Promotion of Maternal and Newborn Health (UP, India). PowerPoint Presentation. Entertainment–Education Conference in New Delhi, November 2011.	

Background

Relatively simple acts can improve neonatal health, such as cutting umbilical cords with sterile blades, using skin-to-skin contact to keep newborns warm, recognizing danger signs that warrant hospital care, and taking advantage of health services when they are available. The problem emerges when mothers and families do not know about them. To help address this problem in selected areas in India where newborn deaths were high, Sure Start was created to help families in crowded urban slums and in rural areas understand the steps they can take to help their babies survive and thrive.

Goals and Objectives

The overall goal of Sure Start was to enhance maternal and neonatal health, with specific objectives being to increase institutional delivery and promote positive newborn practices.

Target Audiences

The target audience was pregnant women and women of child-bearing age, as well as health care providers.

Process and Strategies

Key features of both the rural and urban programs included the following:

- **Working with government agencies** at the district and sub-district levels, as well as with NGOs and CBOs.
- **Using a number of creative methods** to convey important information about maternal and newborn health to communities. In both Uttar Pradesh and Maharashtra, the program used interactive and entertainment tools, including dance, music, theater, and games, to create awareness.
- **Centering communication efforts around five key messages**, cord care, thermal care of the newborn, immediate and exclusive breast feeding, birth preparedness, and danger sign recognition were emphasized.
- **Offering needs-based BCC** ensured that they were responding more effectively to the varying and specific needs of every woman, BCC focused on "providing need-specific information and counseling based on behavioral diagnosis." A checklist was prepared to identify and diagnose issues related to desired maternal and newborn health behaviors. Based on these behavioral issues and their underlying causes, project workers provided BCC and counseling in a manner that enabled beneficiaries to overcome challenges and modify their behavior.
- **Using a well-defined outreach protocol**, a pregnant woman was visited three times during her second and third trimester. Providers discussed different information during each visit, thereby offering a staggered approach rather than providing information all at once. This was done so that the woman and her family members were able to understand and mentally retain the information discussed. During subsequent home visits, behaviors were tracked and recorded. Challenges, if any, were identified and counseling was offered. The value of need-based BCC and segmentation of audiences based on their specific needs has been corroborated in several studies.[13]

Sure Start's urban Maharashtra program involved:

- Mobilizing the community, creating demand, and facilitating an enabling environment for individual, household, and community action.
- Promoting household skills and healthy behaviors for essential maternal and newborn care.
- Facilitating access to skilled birth attendants and essential commodities such as safe delivery kits and antibiotics to manage severe infections.
- Strengthening community-level networks to promote collective action.
- Strengthening linkages between communities, health care systems, and public and private service providers.

[13] The right message, at the right time, at the right place. Catherine Toth, World Vision India and the United States. 2008.

- Testing seven different approaches in each of its urban locations: a health insurance and financing scheme (Nanded), volunteerism and self-help groups (SHGs) (Solapur), convergence of maternal and neonatal health (MNH) and HIV (Pune), public–private partnerships (Navi Mumbai), insurance (Nagpur), quality of care/client satisfaction norms (Malegaon), and quality of care (Greater Mumbai).

Key components of strategic communication used in the urban program were:

- A well-publicized campaign that highlighted government support for MNH, including the involvement of senior public officials such as the Chief Minister and Health Minister. This helped bolster the campaign's visibility and credibility.
- Household-level IPC that was segmented based on the specific needs of the individual woman, as well as customized to the different language and cultural contexts of a vast immigrant population. Providers also gave plastic tiffin boxes so that pregnant woman could set aside food for herself, a birth preparation calendar, and a piggy bank for savings.
- Communication materials were displayed at all of the health posts and centers of the Navi Mumbai Municipal Corporation.
- Interpersonal communication was conducted via home visits by trained community health workers (CHW).
- A professional media advocacy group helped ensure that the schemes were widely publicized and covered by the news media.
- A set of flash cards was developed through a participatory process and pretested for comprehension. The text and pictorial messages were designed to suit the beneficiaries' process of absorbing new information; the health workers were trained to use these job aids as part of conducting needs-based BCC.

Sure Start Project Results

- Decreased home deliveries and increased institutional deliveries
- Improved women's care-seeking behaviors as well as maternal and neonatal health practices

The rural Uttar Pradesh program involved:

- Mothers' groups in which the local caregiver facilitated meetings to increase awareness of issues in MNH through entertainment methods: dolls, games, music, and dance. Since January 2008, 80,000 group meetings with 12,000,000 expectant mothers and mothers-in-law were held.
- Capacity building of 7,540 Accredited Social Health Activists (ASHAs).
- Increased male participation in reproductive health through "letters from the unborn child" to the prospective father.
- Catalyzing VHSCs to facilitate improved primary health care facilities. These committees disseminated essential information such as emergency phone numbers, names of doctors, contact information for transportation facilities, and contributed to increasing payments from the Janani Suraksha Yojana (JSY).
- Launching an extensive mass media campaign called Pehla Ek Ghanta (The First One Hour) in each of the seven districts. This included outfitting 750 automobiles with MNH information, quizzes, screened films with MNH content, and wall writings.

Good Practices

- **360 approach:** Sure Start employed a multi-pronged approach, building on community engagement combined with provision of services and mass media.
- **Detailed audience segmentation:** Sure Start used a needs-based, finely tailored BCC approach rather than generic "one-size-fits-all" messages so that information was relevant and useful to the very specific needs of individual women. Differently colored and coded ANC registers and needs-specific IPC session plans served as effective job aids for frontline workers.
- **Focus on sustainability:** A key to Sure Start's success was integration with government entities to facilitate implementing to scale. As part of this, the project addressed the issue of a dearth of government health workers and systems for outreach and BCC by mobilizing CHWs who were accessible to the community.
- **High-quality media programming:** Innovative and creative campaigns, such as the mid-media campaign Pehla Ek Ghanta, increased momentum and buzz, and mobilized diverse stakeholders. The campaign creatively disseminated maternal and newborn health-related information through the use of games, street plays, flipbooks, film screening, and jingles.
- **Strong/innovative partnerships:** Sure Start also combined demand-generation with enhanced access to quality health services through mothers' groups and VHSCs, community insurance, and monitoring committees. The project's efforts to enhance the role of quality, affordable and accessible health care services, the introduction of community-based health insurance, and emergency health funds, and the linkages with existing government health schemes helped to bolster the BCC with credibility and increased the likelihood of behavior change being adopted. For example, the 30 monitoring of MNH status (MOMS) committees in Pune were instrumental in creating a bridge between the community and the medical practitioners.
- **Targeting of MCH influencers:** Because it was found that men were key financial decision-makers in most households, Sure Start began reaching out to men, which resulted in a rapid enrollment increase into health insurance schemes. Men were also included in MOMS committees in Pune, with clearly defined gender roles relevant to the community's social context. For example, while female members reached out to new and expectant mothers, men were responsible for logistical details, such as organizing transportation and blood services.

2. Smiling Sun	
Donor: USAID **Implementing agency**: Bangladesh CCP with technical support from the Johns Hopkins University/Center for Communication Programs (JHU/CCP) Baltimore. The campaign was implemented under the National Integrated Population and Health Program (NIPHP), and involved 30 local NGOs. The third phase of the program was managed by Pathfinder International.	**Good Practices:** • 360 approach • Communication planning cycle • Extensive provider training/support • Strong product/service branding
Duration: In three phases: 1997–2003; 2003–2007; 2007–ongoing **Geography:** Bangladesh	

Publication/Source:

1. Evaluation of Smiling Sun Campaign. BCCP and AC Nielsen Bangladesh, Ltd., Bangladesh March 2003.
2. Overcoming Methodological Challenges in Evaluating Health Communication Campaigns: Evidence from Rural Bangladesh. *Studies in Family Planning* vol. 42 issue 2 June 2011. p. 93-106.

Background

The symbol of the "Smiling Sun" was launched in January 2001, standing for quality and caring health service "with a smile" in the Paribarik Shastha Clinic. The symbol is associated with the slogan "Come with your family for health care."

Goals and Objectives

The goal of the project was to increase public familiarity with—and positive perceptions of—the Smiling Sun logo and increase client traffic to clinics and facilities established under the Rural Service Delivery Partnership (RSDP) and Urban Family Health Partnership (UFHP) clinics. During the third phase of the program, starting in 2007, these two categories of clinics were merged under the NGO Service Delivery Partnership (NSDP).

Target Audiences

Women of child-bearing age (and their families) who would need to access health care to receive antenatal care (ANC), postnatal care, child immunization, and other health care.

Process and Strategies

The Smiling Sun symbol and slogan were promoted through broad-based, multi-faceted and multi-channel campaign, which involved:

- An **outdoor media and mass media campaign,** including radio spots, newspaper ads and a 26-episode television drama serial called "Now Cloud, Now Sunshine" (Eyi Megh Eyi, Roudra in Nepali). The TV drama highlighted the Smiling Sun clinics and health-oriented issues.
- **Capacity building of service providers** through brand orientation to improve the marketing and service promotion skills of the service providers, and strengthen the linkages between quality of care standards and the brand at service provision.

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- **Community engagement** to create a more conducive environment among key local community stakeholders and gatekeepers to support optimal clinic and service use, especially among women and children. This included local and cost-effective channels, such as doorstep promotional drives, interactive sessions using traditional media such as folk songs, street dramas, puppet shows, and courtyard meetings.

Good Practices

- **360 approach:** The project used a broad-based approach—outdoor and mass media, capacity building of service providers, and community engagement—to reach the target group and influencers, focused on the Smiling Sun name, symbol and slogan.

- **Communication planning cycle:** The project developed a number of technical documents that enhanced its effectiveness and outcomes. These included an Implementation Plan that covered preparatory activities; development and production of campaign support materials; manuals for each activity, such as a brand manual, a creative brief for TV advertisement, templates of various promotional materials; a campaign guidebook; and a concept for the marketing toolkit.
- **Extensive provider training/support:** Capacity-building of providers was buttressed by an assortment of job aids on topics such as acute flaccid paralysis AFP card and the Tiahrt Amendment (related to family planning). These contributed to a higher technical capacity and a wider range of services, making the Smiling Sun competitive with other services synonymous with quality services in health care.
- **Strong product/service branding:** The highly promoted campaign and brand name ensured that the Smiling Sun logo was recognized by almost two-thirds of respondents, most of whom also could name that specific MCH services were available there. The "service with a smile" slogan was designed to reinforce the brand name/logo.

3. Pakistan Initiative for Mothers and Newborns (PAIMAN)	
Donor: USAID **Implementing agency:** Consortium led by JSI Research and Training Institute, Inc., JHU/CCP, National Research and Development Foundation	**Good Practices:** • 360 approach • Focus on sustainability • Strong/innovative partnerships • Targeting of MNCH influencers
Duration: October 2004–2010 **Geography:** Pakistan – 10 districts initially, and in 2008, based on an additional grant, expanded to 14 additional districts, 2 Frontier Regions and Federally Administered Tribal Areas	
Publication/Source: 1. PAIMAN Communication, Advocacy and Mobilization Strategy. JHU-CCP and JSI. n.d. 2. PAIMAN Project Completion Report, October 2004 – December 2010. JSI. 3. PAIMAN: Process Evaluation of Community Mobilization Activities. Shah, Z.H. Population Council, JSI April 2010. 4. *Ulama – Agents for Social Change: Muslim Scholars Speak for Mothers Rights*. Butt, A.I.; Sood, S; Khan, F.A; *et al*. JHUCCP. Islamabad, Pakistan 2010.	

Background

MCH rates in Pakistan are among the worst in South Asia, as measured by IMR, number of live births, MMR, high fertility rates, a high unmet need for FP, and very low rates of skilled birth attendants. Additional factors compound this situation, including political instability, poor governance, rising religious conservatism, poor literacy, low status of women, and an under-resourced and under-functioning public health service delivery system. Against this backdrop, PAIMAN was established to increase quality of, attitudes toward and the use of maternal and child services.

Goals and Objectives

The project's objectives were to:

- Increase awareness and promote positive maternal and neonatal health behaviors

- Increase access (including essential obstetric care) to and community involvement in MCH services, ensuring that services are delivered through health and ancillary health services
- Improve service quality in both the public and private sectors, particularly related to management of obstetrical complications
- Increase capacity of MNH managers and care providers
- Improve management and integration of services at all levels
- Build capacity of community-based religious decision-makers and engage them to advocate to men on behalf of maternal, newborn, and child health (MNCH) issues

Target Audiences

The project focused on currently married women of reproductive age as the primary target group, as well as key religious decision makers in the community.

Process and Strategies

The project used a multipronged strategy, with key activities that included: creating awareness and demand for services, capacity building, technical assistance, continuing education for service providers and managers, and investing in health system planning, management, and monitoring.

The communication component of the project involved:

- **Home visits and small support group activities** through lady health workers (LHWs) and CHWs, and IPC through the private sector.
    - Government LHWs were trained for five days in BCC methodology so that they could lead community support groups. The groups met every two weeks and provided women the opportunity to discuss health problems, issues, and solutions. LHWs also conducted home visits, and provided family planning, iron folate and other basic medicines, and allowed women to address concerns they may not have wanted to share publicly.
    - Greenstar Social Marketing—a project partner—promoted its Good Life private sector clinics through a variety of mass media (TV spots, billboards) and IPC activities. The project also ensured that providers conducted three clinic "Sahoolat" (free service) days to encourage the uptake of services by disadvantaged women in their catchment area.
    - Community theater implemented at events or health facilities and Putlee Tamasha (puppet theater) integrated MNCH messages into a traditional community entertainment form.

- **Health camps and events** through 37 local NGOs that reached out to underserved rural communities not accessible by LHWs. The NGO outreach included the mobilization of approximately 740 CHWs. PAIMAN events included medical camps and village and health fairs (for example, offering tetanus toxoid vaccinations and antenatal checkups).
- **Mass media initiatives**, including:
    - A 13-episode drama series, televised on Pakistan Television (PTV-Home) every Sunday night. Each episode was based on real-life, sensitive issues (such as FP) related to mothers and newborns.
    - A 10-episode, district-specific TV talk show on MNH topics for national telecast.
    - Five 20-second television PSAs, each addressing a key MNH area.

- A music video positioning pregnancy as an important life stage, and emphasizing male and extended family responsibility in pregnancy and childbirth.

- **A variety of community-based committees**, such as:
  - Village health committees (VHCs) consisting of men who would help LHWs disseminate MNH messages to other men in the community.
  - Citizen community boards (CCBs), or government-recognized committees that received funds from district governments to help them improve local conditions.
  - Facility-based health committees (FBCs), which aimed to improve the links between communities and the nearest health facility.
  - Quality improvement teams (QITs) with the same function as FBCs.
  - Central *shora* (committee) composed of nationally renowned and well-respected *ulama* to provide strategic oversight and policy guidance and sensitize individual ulamas.

- **Advocacy with government officials at all levels, journalists, and religious leaders** or ulamas. In the case of ulamas, activities included a careful mapping of influential mosques in select districts, especially in areas with no access to radio or TV and few CHWs. Through individual meetings, ulamas were presented with diverse, evidence-based materials, together with a small book titled the "Role of Ulama in Promoting Maternal, Newborn and Child Health," which used the Quran and Hadith as its main reference points. The ulamas were asked to talk about MCHN issues during the Friday morning prayers and advocate for the issue.

PAIMAN Project Results
- Reduced neonatal mortality rate
- Increased proportion of skilled birth attendants (SBA) assisted live births
- Increased engagement of ulamas

- **Capacity-building** of 550 female private providers on essential maternal and newborn care (ENMC) by Greenstar, using PAIMAN's trainers and curriculum.

- **Promotional materials** on the importance of mother and child health in Islam. Articles were also written for the magazines of prominent seminaries.

Good Practices

- **360 approach:** A variety of community-based activities (home visits and support group activities, community-based committees, health camps and events) were complemented by capacity-building of female private providers, advocacy with all levels of government, journalists and religious leaders and supported by a variety of mass media programming.

- **Focus on sustainability:** Critical to PAIMAN's success was the fact that it did not create any new institutional structures or parallel systems, but worked within existing institutional arrangements in the public health system, thus ensuring sustainability. The project worked to strengthen public health systems, and built capacity for planning, management, supervision, and monitoring capacity at the district level. PAIMAN worked closely with various tiers of health workers at the village and community levels, such as community midwives, LHWs, and traditional birth attendants who were expected to continue in the community well after the project ended. The program created a certain vitality and urgency regarding MNCH and helped to place the issue high on the Government of Pakistan's (GOP's) agenda.

- **Strong/innovative partnerships:** PAIMAN worked with the private sector to help enhance the scope of services for MNCH, with a focus on public–private partnerships that involved sustainable arrangements—such as transportation for obstetrical emergencies—that were expected to last beyond the project life and provide a model for others. PAIMAN also worked closely with the media and invested in the long-term city of print and electronic media. PAIMAN has been credited with contributing to raising awareness about MCH in the media. Partnerships were forged with religious groups and leaders, and NGOs. A national conference on MCH was held midway through the project, and was attended by over 250 ulamas and high-profile religious leaders, demonstrating that the project had their blessings.
- **Targeting of MNCH influencers:** Program managers were successful in engaging ulamas to take action in their communities by being cognizant of customs and Islamic teachings. For example, the practice of gifting sweets created goodwill, and senior ulamas appreciated of program staff travelling long distances to obtain their input. In the end, the ulamas understood how religious leaders could facilitate a dialogue on the MNCH issues related to religious injunctions, and could demonstrate how harmful practices could not be allowed in the name of religion.

4. Manoshi	
Donor: Bill & Melinda Gates Foundation's Community Health Solutions (CHS) Initiative **Implementing agency:** Bangladesh Rural Advancement Committee (BRAC) Technical assistance provided by the International Centre for Diarrheal Disease Research.	**Good Practices:** • 360 approach • Participatory processes • Robust research
Duration: 2007–2011 **Geography:** Bangladesh – Urban slums of six city corporations (Dhaka, Chittagong, Sylhet, Rajshahi, Barisal, and Khulna) and 15 statistical metropolitan areas of Dhaka	
Publication/Source: 1. BRAC Envisage Achievement of MDGs 4 and 5 through Innovative mHealth Solution Partnering with ClickDiagnostics. n.d. 2. Manoshi: A Community-based Solution to Avert Maternal Death (Abstract). Chowdhury, T; Afsana, K; Sarker, S. 13th ASCON 2011. 3. Manoshi Working Papers. ICDDR. 2009–2012. 4. The Manoshi Maternal, Neonatal and Child Health Project in Bangladesh (Presentation). Christian Connections for International Health Annual Conference in Buckeystown, Maryland. 11–13 June 2010.	

Background

About one-third of the population in Bangladesh lives in urban areas, with the worst health situations in slums and among squatters in cities. To improve the health situation of mothers, newborns, and children in urban slums in Bangladesh, the Manoshi community-based health program was launched in 2007 within urban slums of six city corporations around Bangladesh through development and delivery of an integrated, community-based package of essential health services.

Goals and Objectives

The overall goal of the program was to develop and sustain a community-based health package to tackle the illnesses and deaths of mothers, newborns, and children in urban slum populations. Specific objectives included to:

- Define, test, implement, and scale up five interrelated components of BRAC essential health services package for women and children.
- Develop a financing strategy for sustaining the program post grant funding.

Target Audiences

Primary audiences were newly married couples, eligible couples (married women of reproductive age between 15–49 years who have had at least one pregnancy and are currently married), and pregnant and lactating mothers and their family members. Secondary audiences were traditional birth attendants (TBAs), CHWs, alternative health care providers, drug-sellers, and local community members. Tertiary audiences included government and local government officials, political leaders, NGOs, health professionals, teachers, religious leaders, and other stakeholders.

Process and Strategies

The project used the village organization (VO) consisting of about 40 community members as a nucleus for the program. CHWs were chosen from the VO, which conducted awareness-raising activities, training (legal and human rights), and served as a recruitment pool for CHWs.

Key program strategies included:

- **Capacity building of CHWs** selected from among the BRAC VO; urban birth attendants selected from among TBAs; and community midwives selected from the pool of existing midwives. They all were trained in MNCH as well as health communication.

- **Selection and capacity development of alternative health care providers** to detect and refer neonatal and birth complications immediately to pre-selected referral centers in slums.

- **Establishment of "birthing huts,"** which are small, hygienic health facilities in slums that provide care for normal vaginal delivery and referral care BCC messages promoted these facilities and encouraged women to deliver at the birthing hut rather than at home.

- **Provision of health services** running the entire gamut from identification and registration of pregnant women; antenatal/intranatal/postnatal care; and under-5 child health. In the case of complications, women were ensured comprehensive EmOC in pre-selected referral facilities.

- **Referral of complications** to private- or public-sector facilities selected by CHWs in coordination with the BRAC manager based on accessibility and availability of services. A memorandum of understanding was signed with these providers and a strong partnership was built to ensure quality of care for EmOC and neonatal/child health complications at low costs. CHWs helped organize transport to facilities through local drivers pre-selected by MNCH committee.

- **Pregnancy registration fees and safety nets** were introduced to cover health care and make the program sustainable. Upon registering with the program, women were offered a package of essential services, as well as partial treatment costs for caesarean sections and neonatal

complications in the hospitals. An emergency fund was created at the community level to secure healthcare in case of life-threatening crises, especially for extremely poor people.

- **Community empowerment** was facilitated by building community and stakeholder capacity as active partners in health improvement. Community support networks, women's support groups and spouse forums actively involved the stakeholders and beneficiaries in the project activities.

- **Inter-sectoral collaboration whereby** BRAC health staff built linkages between different BRAC programs to help with microfinance, income generation, and education of children.

The BCC component of the project was conducted through three core components: IPC or face-to-face counseling conducted by CHWs; group counseling; and mass media. Multiple channels and formats were used, such as group meetings (women's support groups, spouse forums, MNCH committee meetings), posters, leaflets, stickers, TV spots, folk songs, and street drama. The communication messages focused on:

- Reducing delay in decision making to access EmOC care
- Influencing attitudes of the main decision makers of the household (husband, mother-in-law)
- Increasing acceptability of facility delivery instead of home delivery
- Increasing transition to appropriate FP methods postpartum
- Increasing knowledge and practice of correct maternal care and newborn/child care practices
- Dispelling misconceptions, including food taboos and eating patterns, mobility restrictions, and the belief that "evil spirits" cause pregnancy complications

Manoshi Project Results

- Significant increase in MNCH knowledge
- Decreased MMR
- Increased postnatal care and colostrum feeding
- Increased awareness and uptake of ANC
- Increased use of BRAC delivery centers by slum residents
- A shift from traditional healers to qualified medical practitioners

The program found that TV spots and informative stickers were more likely to influence MNCH knowledge among women. Women were asked to keep stickers and posters given during communication sessions as reminders on how to detect the danger signs of pregnancy and neonatal complications, and featured emergency contact information for the CHWs.

Good Practices

- **360 approach:** Use of all channels of communication at appropriate times and frequencies increased the acceptance of project services. Focused messages influenced long-term attitudes and practices regarding prenatal, postnatal, and neonatal care, as well as maternal and neonatal complications. Addressing men in the family improved decision-making to seek appropriate care.

- **Participatory processes:** Intensive community involvement at the planning, implementation, monitoring, and evaluation levels increased the sense of ownership toward the project and commitment to MCH issues. The program capitalized on existing community resources by involving TBAs and community midwives and alternate medicine practitioners and building their capacities.

- **Robust research:** Significant monitoring and evaluation included structured pretesting of communication materials and helped to ensure that the materials were culturally sensitive, yet clear in conveying important information. For example, based on feedback from the pretesting, the program redesigned visuals which, being physically explicit, embarrassed the families and reduced the probability of these materials being kept in their homes. In addition, using ClickDiagnostics software, CHWs used their mobile phones to collect vital patient information and were able to identify 86 percent of all pregnancies in the selected areas, 81 percent of which were provided with antenatal care and 80 percent with postnatal care on at least three occasions.

Programs Focusing Primarily on Community-Based Interventions

5. Community Led Initiatives for Child Survival (CLICS)	
Donor: USAID **Implementing agency:** Aga Khan Foundation in partnership with the Department of Community Medicine (DCM), Mahatma Gandhi Institute of Medical Sciences, Wardha	**Good Practices:** • Focus on sustainability • Participatory processes • Strong/innovative partnerships
Duration: October 2003–September 2008 **Geography:** India – 67 villages in Wardha district, Gujarat.	
Publication/Source: 1. A community-based approach to improve health care seeking for newborn danger signs in rural Wardha, India. Dongre, A.R.; Deshmukh, P.R.; Garg, B.S. *Indian Journal of Pediatrics* vol. 76 issue 1 January 2009. p. 45-50. 2. Communities for Children: Selected Good Practices in Improving Children's Wellbeing through Community Participation. Save the Children, Public Interest Foundation Study. August 2009. 3. Community-Led Initiatives for Child Survival (CLICS). Child Survival Program – India: Final Evaluation. Aga Khan Foundation, USA. December 2008. 4. Community Led Initiatives for Child Survival Program (CLICS). Annual Report. USAID. October 2006.	

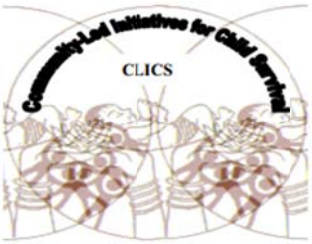
Background

CLICS was intended to facilitate community ownership of a package of health services by refining and using a social franchise model that was demand-driven and sustainable. The communities where CLICS was implemented had relatively high neonatal mortality rate, IMR. The target districts were in areas of low socioeconomic status (SES), limited community resources, and high rates of morbidity and mortality among the most vulnerable groups—newborns, infants and their mothers.

Goals and Objectives

The goal was to enhance child survival among rural communities through provision of high-quality, affordable services. The objectives were to:

- Create a sustainable health care system at the village level for improving the health status and well-being of children under the age of 3 years and women of reproductive age through affordable, high-quality care with effective partnerships at the community level.
- Create awareness about preventive health practices for promoting behavior change.



Target Audiences

The target group was children under the age of 3 years and women of reproductive age in rural areas.

Process and Strategies

The program focused on the role of VCCs in the delivery of decentralized health care. Built on a social franchise model, the community enters into a contract or agreement with a private-sector entity to produce a "social product." The program promoted BCC strategies for newborn care, and improved

access to maternal and newborn health services through a cadre of CHWs. The program's social product was a package of health care services delivered at the village or community level.

Other components of the program included:

- **Mobilizing and organizing communities to form Village Coordination Committees (VCCs),** which were responsible for decentralized health care delivery at the village level. The VCCs composed of CBOs, auxiliary nurse midwives (ANMs), and AWWs were oriented on health issues in the rural areas, and then conducted an assessment of the community health needs, planned relevant interventions, delivered appropriate services, and assured the quality of these services. CBOs were formed or strengthened, including women's SHGs, Kisan Vikas Manch (Farmers' Development Associations), and Kishori Panchayat (Adolescent Girls Forum). Subcommittees on health, sanitation, and communication were formed under the VCC. Inclusion of a variety of community members was accomplished by the following:
  - Kishori panchayats were used for adolescent girls to mobilize and voice their needs and act as peer educators. The VCCs also encouraged representatives from the kishori panchayats to participate in village decisions that affected their lives.
  - SHGs were used to encourage the participation of women, who acted as change agents.

- **Implementing a social franchising model through the VCCs** based on a social franchise agreement document that outlined a clear set of health priorities and the means to address them. Once the agreement or contract is defined, the Department of Community Medicine (DCM) supports the VCC to implement activities focusing on the agreed package of health services for the community.

The project used a **BCC strategy** to improve access, availability, and equity of health services for the community. This included activities such as:

- Identifying and training VHWs the VCC to facilitate key positive health behaviors.
- Conducting monthly child survival days Bal Suraksha Divas (as per GOI norms) organized by the VCC. Though mandated with MCH, these days typically only focused on immunization and antenatal care. Under the CLICS program, these activities were expanded to include postnatal care, growth monitoring of children (0–3 years), and a small group session on nutrition and health education.

Good Practices

- **Focus on sustainability:** CLICS worked through existing public health groups and resources to offer a holistic approach to health care, which aimed to reduce not only infant and neonatal mortality, but also improve the health status of children and women. By working through existing community groups, CLICS helped to mobilize communities, build their capacities, and create an enabling environment for women and adolescent girls. The program also integrated the facilities of the public health system with the program and mobilized the support of Panchayat Raj Institutions (PRIs) which had long-term advantages for its continuity. This included the development of village-specific sustainability

CLICS Project Results

- Increased health facilities deliveries
- Decreased infant and neonatal mortality rate (2006–2008)
- Facilitated the formation of community-based organizations, such as SHGs, Adolescent Girls Forum, Farmers' Development Association

plans by the VCCs along with cost recovery mechanisms for retaining health workers and operating community clinics.

- **Participatory processes:** Members of the VCCs and other stakeholders were kept informed about the progress of planning health activities, and were invited to provide their input for improved outcomes. Moreover, making the VCC responsible for mobilizing and managing funds led to it becoming self-reliant and accountable.
- **Strong/innovative partnerships:** In addition to engaging and strengthening the VCCs, the project also energized Kishori Panchayats, which not only influenced community members on MCH issues but also mobilized support for development issues such as hygiene, sanitation, literacy, and girls' rights. CLICS also linked health programs and initiatives with broader livelihood options, such as agricultural training and education for the village men and discussions on credits and saving with the SHGs. These opened up additional avenues of active interaction.

6. Muskaan Ek Abhiyan (The Smile Campaign)	
Donor: Government of Bihar and UNICEF **Implementing agency:** Bihar Health Society; technical support from UNICEF and National Polio Surveillance Project (NPSP)	**Good Practices:** • Extensive provider training/support • Strong/innovative partnerships
Duration: 2007–ongoing **Geography:** India – Bihar state	
Publication/Source: 1. Effectiveness of Muskaan Ek Abhiyan (The Smile Campaign) for Strengthening Routine Immunization in Bihar, India. Goel, S; Dogra, V; Gupta, S.K. *et al. Indian Pediatrics* vol. 49 issue 2 February 2012. p. 17–19. 2. Social Mobilization Network Mobilizes Support to Strengthen Routine Immunization in Bihar. UNICEF *India Communication Update* vol. XXII October 2009. p. 2–4.	

Background

In Bihar, complete routine immunization coverage has been slowly progressing from 11.8 percent (NFHS-2) in 1998–1999 to 18.6 percent (Coverage Evaluation Survey) in 2005. Routine immunization activity was further strengthened the next year, and 2006 was designated as the Year of Immunization by the state. In this year, several rounds of Immunization Weeks were organized wherein missed sessions were caught up and hard-to-reach areas were targeted with immunization activity. As a result, full immunization coverage rose to 32.8 percent (NFHS-3 2005–2006). Buoyed by this success, a year-long campaign was launched by the Government of Bihar in October 2007 called Muskaan ek Abhiyaan (MEA), or the "Smile Campaign."

Goals and Objectives

The objective of the campaign was to achieve 100% immunization coverage of infants and pregnant women in Bihar.

Target Audiences

The target audience was pregnant women and mothers of young children.

Process and Strategies

- **The program involved mahila mandal groups,** which conducted monthly meetings for pregnant women and mothers of young children to create awareness on issues related to health, immunization, and nutrition. Initially (2007–2008), Rs 150 was allocated per anganwadi center (AWC) per month for *Mahila Mandal* meeting expenses; this was raised to Rs 250 in 2009. However, this grant was discontinued in Phase 2 as the budget allotted for *Mahila Mandal* meetings came out of the VHSC funds.
- **Inter-sectoral coordination** between the Integrated Child Development Services (Department of Women and Child Development [DWCD]) and health department was enforced by a joint government order. The ANM acted as the team leader of 5 to 10 AWCs. AWWs and ANMs conducted a time-bound, cross-sectional, house-to-house survey to identify all currently pregnant women and children in the under-2 age group. Follow-up surveys were conducted monthly to identify new pregnancies and newborns. All identified pregnant women and 0- to 2-year-old children were registered in pregnancy and newborn tracking registers, respectively. Before each immunization session, ASHA of the AWC mobilized the pregnant women and children using the tracking register. In addition to routine immunization activity, three rounds of special immunization weeks were conducted statewide.
- **Performance-based incentives were given to service providers.** For coverage of less than 60 percent, explanations were sought in their weekly and monthly review meetings. Financial incentives were given under the second phase of the program.
- **Enhanced political commitment and budgetary allocation** allowed District Immunization Officers and Medical Officers In-charge to be trained at the state level. They, in turn, could train all of the health workers in their respective districts**.**
- **The program strengthened monitoring and supervision mechanisms, including updating and cross-verification** of beneficiaries. Supportive supervision at primary health care facilities involved releasing monetary incentives only on the basis of tracking registers and the presence of workers at sites; at the block level through inter-sectoral steering committees; and at the district level through the district health society and chaired at monthly meetings by the district magistrate. Independent monitoring was also conducted by UNICEF, NPSP, and state and district officials of the government.

Traditionally, routine immunization (RI) sessions were held at sub-centers on every Wednesday and in one AWC every Saturday. The micro plan was revamped and ANMs also conducted RI sessions on every Friday in two to three AWCs. In first phase of *Muskaan* (October 2007–August 2009), immunization sessions were also based at health facilities and AWCs. However, in the second phase (September 2009 and after), immunization sessions were extended to villages and hamlets where a health facility or AWC did not exist. The revised micro-plan ensured that all AWCs are covered at least once every month.

***Muskaan ek Abhiyaan* Project Results**

- Increased proportion of fully immunized children 12–23 months old
- Marked improvement in immunization coverage after the launch of the campaign
- Increased presence of AWWs and ASHAs

UNICEF, through its Social Mobilization Network (SMNet), provided support for the implementation of this campaign. SMNet has assisted in training workers and developing new micro-plans for this

campaign in primary health centers. The interventions in *Muskaan ek Abhiyaan* are regularly monitored by around 311 SMNet coordinators and other functionaries of UNICEF and NPSP.

Good Practices

- **Extensive provider training/support:** Budgetary allocations allowed all health workers to be trained and provided incentives based on performance. The timing of this campaign coincided with the launch of the NRHM, which dramatically increased the pool of frontline workers such as ASHAs. The larger number of frontline providers used the project's complete package of interventions, and ultimately helped to improve the service delivery of vaccine. This brought immunization services closer to the communities and ensured immunization even in small hamlets and villages with no AWCs.
- **Strong/innovative partnerships:** Support for the project was provided by a core group of highly dedicated social mobilization professionals, which included Block Mobilization Coordinators and Social Mobilization Coordinators of SMNet. Their quality time and service played a critical role in making the project a success. Inter-sectoral coordination between the integrated child development scheme (ICDS) and health department was enforced by a joint government order.

7. Saving Newborn Lives/Projahnmo/MaMoni	
Donor: USAID, Save the Children (grant from the Bill & Melinda Gates Foundation) **Implementing agency:** Johns Hopkins Bloomberg School of Public Health, ICDDR, Shimantik for Projahnmo	**Good Practices:** • Extensive provider training/support • Focus on sustainability • Strong community-health services linkages
Duration: June 2000–January 2014 **Geography:** Bangladesh – Sylhet district (BRAC pilot) 2003–2004	
Publication/Source: 1. Community-Based Intervention to Reduce Neonatal Mortality in Bangladesh. Baqui, A and El-Arifeen, S. Final Report 2007. 2. Effect of community based newborn-care interventions package implemented through two service delivery strategies in Sylhet district, Bangladesh: a cluster randomized controlled trial. Baqui, A.H.; El-Arifeen, S; Santosham, M; Black, R.E.; *et al*. *The Lancet* vol. 371 issue 9628 June 2008. p. 1936–44. 3. Saving Newborn Lives in Rural Communities: Learning from the BRAC Experience. Hadi, A; Ahmed, M. BRAC Research Report, December 2005.	

Background

In 2009, the USAID-funded Maternal and Child Health Integrated Program (MCHIP) received an associate award to improve maternal and neonatal outcomes in the Sylhet and Habiganj divisions of Bangladesh. Titled "MaMoni – Integrated Safe Motherhood, Newborn Care and Family Planning Project," the project aimed to increase healthy maternal and newborn behaviors in a sustainable and scalable manner.

MaMoni was somewhat based on materials from the Projanhmo project, which involved a community-based MNH care package and a home care package to advance the health

of newborns and mothers. The latter employed CHWs in conducting antenatal and postnatal home visits and management of sick newborns.

Goals and Objectives

MaMoni sought to increase the use of high-impact MNH behaviors, including FP, and to strengthen the MoHFW systems to provide quality MNH/FP services.

Program objectives included:

- Increasing knowledge, skills, and practices of healthy maternal and newborn behaviors in the home
- Increasing appropriate and timely utilization of home- and facility-based essential MNH and FP services
- Increasing acceptance of FP methods and advancing understanding of FP as a preventative health intervention for mothers and newborns
- Improving key systems for effective service delivery, community mobilization, and advocacy
- Mobilizing community action, support, and demand for the practice of healthy MNH behaviors
- Increasing key stakeholder leadership, commitment, and action for these MNH approaches

Target Audiences

The target audience was pregnant women and women who had recently given birth.

Process and Strategies

MaMoni had four key areas of focus:

- Maternal and newborn care and FP training for health workers to improve basic services
- Introduction of skin-to-skin Kangaroo Mother Care (KMC) as a means to improve the thermal regulation of newborn babies
- BCC approaches to promote healthful maternal newborn and FP practices
- Community engagement through community action groups (CAGs) to provide maternal tetanus immunization and FP services

Several BCC approaches were harnessed to ensure uptake of adequate antenatal health services, promotion of safe delivery, management of complications, and adequate postnatal care (PNC). Family welfare assistants and female welfare visitors were trained to provide counselling to women, supported by BCC materials. CAGs provided some information at their monthly meetings, and there was some use of mass media channels (such as videos, phones). The project used grassroots women as front runners to identify pregnant women, IPC at home, and conducted community meetings on health topics (Uthan Baithak meetings), workshops, advocacy, and popular theater. Other approaches used included:

***Projahnmo/MaMoni* Project Results**

- Increased ANC, delivery hygiene, delayed birthing, immediate breastfeeding
- Increased essential newborn and postnatal care
- Increased trends in healthy maternal and neonatal behaviors

- **National training of trainers sessions** from both health and FP departments on the integrated MNH-FP package, which included administration of injectable contraceptives and community-based distribution of misoprostol. The national trainers then conducted the trainings at the district level.
- **An outreach strategy that involved customized MNH-FP counseling** during bi-monthly visits to health facilities by government and NGO workers, and visits to households during the pregnancy and postpartum periods that provided counseling on: immediate and exclusive breastfeeding, return to fertility, lactational amenorrhea method (LAM), transition from LAM, and other FP methods for breastfeeding women. Behavior change issues were reinforced at the community level through CAGs, LAM ambassadors or role models, and community meetings with influential women and men to gain support for postpartum FP, including LAM.
- **Systems and quality of care strengthening** at more than 275 public health facilities in Habiganj to improve access to quality MNH/FP services. A baseline assessment addressing service availability, human resources, equipment, drugs, logistics, quality of care, data collection and accuracy, and general conditions was conducted for each facility.
- **Community engagement by both women and men** who volunteered their time to learn about healthy pregnancy and healthy babies and to share their knowledge in the community allowed these communities to take charge of their own health.

Good Practices

- **Extensive provider training/support:** Comprehensive training was conducted a multiple levels for service providers and community workers. Training of CHWs increased the proportion of women receiving early antenatal and postnatal care. Trained TBAs were important providers of delivery and PNC services in the community.
- **Focus on sustainability:** Communication materials developed under the Saving Newborn Lives project have been endorsed and adapted for ongoing use by national governments in several countries, supporting that the interventions can be replicated and sustainable. Sustainability was ensured by intensive involvement of the community through mechanisms such as community action cycles, community clinic management groups, and CAGs. The engagement of men in the CAGs increased their involvement in MNH activities. Collaborative approaches to the development of training and behavior change materials meant that they were widely accepted, used consistent messages, and were technically sound.
- **Strong community-health services linkages:** The home-care strategy to promote an integrated package of preventive and curative newborn care was found to be effective in reducing neonatal mortality in communities with weak health systems, low health care use, and high neonatal mortality. Door-to-door visits by the CHWs using community registers were an effective way to identify pregnant women and follow them through pregnancy to the postnatal period. This was coupled with customized counseling during visits to health facilities.

8. Women's Health Groups in Perinatal Health	
Donors: DFID, WHO, UNICEF, UNFPA **Implementing agency:** Mother and Infant Research Activities (MIRA)	**Good Practices:** • Adaptation of materials to local context • Participatory processes

Duration: 2001–2003 **Geography:** Nepal – Makwanpur district
Publication/Source: 1. Behavior change in perinatal care practices among rural women exposed to a women's group intervention in Nepal. Wade, A; Osrin, D; Shrestha, B.P.; *et al*. *BMC Pregnancy and Childbirth* vol. 6 issue 1 2006. p. 20. 2. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: a cluster randomised controlled trial. Manadhar, D.S; Osrin, D; Shrestha, B.P. *et al*. *The Lancet* vol. 364 issue 9438 September 2004. p. 970–979. 3. Women's Health Groups to Improve Perinatal Care in Rural Nepal. Morrison, J; Tamang, S; Mesko, N; *et al*. *BMC Pregnancy and Childbirth* vol. 5 issue 6 March 2005.

Background

Neonatal mortality rates in Nepal

high, with over 90 percent of deliveries being conducted at home, and only 5 percent with the support of a skilled birth attendant. Primary and secondary care is deficient in rural areas of Nepal, and where services exist, they are underused for a number of complex reasons. The topographical barriers combined with limited expenditure on public health, poor quality of care, a high turnover of service providers, a lack of drugs and supplies, and a lack of ownership of health programs by communities all contribute to issues of demand and supply.

The value of community participation to reduce perinatal mortality has been demonstrated through other projects, notably the Warmi project in Bolivia (Save the Children Federation, USA, and the Mothercare project, USAID), which used community-based women's groups to reduce maternal and neonatal mortality and morbidity. They used a participatory approach involving community diagnosis, planning together, implementation of plans, and participatory evaluation. The Warmi project reported a reduction in the perinatal mortality rate from 117 to 44 per thousand births. The activities initiated by women's groups included literacy programs, savings and credit schemes, and programs to increase access to FP. This experience was used to initiate a similar project in Makwanpur, Nepal.

Goals and Objectives

The project aimed to harness the power of community planning and decision-making to improve maternal and newborn care in rural Nepal, specifically, to reduce perinatal and neonatal mortality.

Target Audiences

The target audiences included women of child-bearing age, pregnant women, and women with children.

Process and Strategies

The project mobilized 111 women's groups in a population of 86,704. The first 10 meetings of the groups' participatory intervention were based on the design of the Warmi project. To enter the communities successfully, the project gathered detailed information on local social networks and organizations, as well as attitudes and practices around the time of pregnancy and birth. Social mapping and qualitative research were conducted and served as a training exercise in facilitating focus group discussions and building rapport in the community. Specific steps were as follows:

- **Working through 24 Village Development Committees (VDCs).** Each covered a population of about 7,000). Links were made with community leaders, district health services, and NGOs.
- **Local facilitator to mobilize women's groups.** In 12 of the VDCs, the project hired a trained female local facilitator to mobilize women's groups. About nine meetings a month were held, and organized with the local female CHW. One supervisor was assigned to three facilitators.
- **Pictorial aids were used due to the low literacy levels of the women.** The first three meetings facilitated discussion on why mothers and newborns die in the community, using a story to identify both medical and social conditions/causes.
- **Community meetings** were conducted to help the broader community understand what the women's groups were doing, with the goal of planning together to develop strategies.
- **A 20-minute film** was shown in 10 of the 12 VDCs, to audiences totaling over 2,000 people.

Women's Health Groups in Perinatal Health Project Results

- Reduced neonatal and maternal mortality rates
- Increased positive changes, such as ANC visits, discarding colostrum, hygienic cutting and dressing
- Women's groups developed and implemented strategies and continued to meet to discuss perinatal health

- **Clean delivery kits were adapted based on local materials**; 19 groups made these kits, with profits going to the mother and child fund.
- **Participatory learning** was promoted through development of a packet of small hand-held cards of different shapes. Each shape of card represented a problem (circle shape), a prevention activity (triangle shape), a home care activity (house shape), or a health institution (square shape). After being piloted with women's groups and adapted accordingly, a manual for facilitators was also developed. Players match the problem cards to their corresponding prevention activities, home care activities, or type of health institution that could treat that problem.

Good Practices

- **Adaptation of materials to local context:** A number of materials were developed focusing on the local context: story-telling, a film, and hand-held cards of different shapes. The pictorial card game worked well in facilitating greater learning, especially in terms of danger signs, home care, and prevention activities. It also helped women strategize more effectively how to deal with specific problems. Group members continued to use the picture cards on visits to pregnant women in the community who were not group members.
- **Participatory processes:** This project showed that maternal and perinatal morbidity and mortality can be addressed even in the most remote and disempowered communities through community planning, decision-making, and implementation leading to varied strategies employed by different groups; 69 groups established mother and child health funds, 19 groups produced clean home delivery kits, and 19 groups raised money themselves, while another 23 groups decided to raise money locally through the VDCs' operating stretcher schemes. Participatory diagnosis and evaluation were also employed.

Programs Focusing Primarily on Mass Media Interventions

9. Kyunki… Jeena Isi Ka Naam Hai ("Kyunki")	
Donor: Partly funded by different government ministries **Implementing agency:** UNICEF	**Good Practices:** • Focus on sustainability • High-quality media programming • Robust research
Duration: 2007–2011 **Geography:** India – National, with focus states for ground-level activities being Uttar Pradesh, Madhya Pradesh, Jharkhand, Rajasthan, Bihar, and Chattisgarh.	
Publication/Source: 1. Challenging Conventions Creatively – Kyunki Jeena Isi Ka Naam Hai. Social Messaging through Television: Paradigms of Change. UNICEF. 2011 2. Mid-term Evaluation of Facts for Life (FFL) TV Drama 'Kyunki Jeena Isi Ka Naam Hai'. 3. Research Highlights: Key Findings from Independent Research of Kyunki. 14 rounds of concurrent assessments. November 2011.	

Background

UNICEF's flagship Facts for Life (FFL) program has played a critical role in advancing the agenda for children's rights, as well as some aspects of maternal and child health. The *Kyunki Jeena Isi Ka Naam Hai* television program was initiated to translate FFL into a television EE format. The series covered 13 issues from the *Facts for Life* book and included 42 videos on specific information areas, a facilitator's guide, and supporting print communication materials. The FFL video series was designed to foster discussion, adopt appropriate practices, and augment behavior change efforts of individuals and frontline workers in a low-literacy environment.

Goals and Objectives

The goal was to create individual and community transformation with regard to key health and development issues, including MCH. FFL's key themes were child survival, development, and protection.

Target Audiences

The primary target audiences were women and other caregivers, women in the 15–35 age group, husbands, and family elders in low-income groups. Secondary audiences were frontline workers and influencers such as teachers and pradhans (working at the grassroots level).

Process and Strategies

The "Kyunki" television program was on air three times a week in the primetime slot of 8:30 p.m. on the national TV network Doordarshan. The initial plan was to develop only 130 episodes on the health and sanitation needs of rural India; however, early signs of the program's success resulted in increased support and prioritization to make it an ongoing program four years later with a total of 501 episodes.

The program involved:

- An EE strategy, proven globally to be a highly effective strategy for promoting individual and social change.
- Attention to messaging through the creation of a message design unit that was responsible for ensuring that the message communicated was factual, clear, and actionable, and to ensure that the message did not get lost in translation.
- Ensuring that a theoretical framework was created for 16–32 episodes at a time, with each track covering one theme. The message design unit interacted closely with GOI representatives, agencies, and experts in the field to ensure that the content was technically accurate.
- Multiple approaches for concurrent monitoring and impact assessment of the program included the following:
    - **Independent content analysis** a) facilitated a comparative analysis of the viewer's comprehension with the intended results of messaging in the show; b) helped scriptwriters, producers, and message designers by offering an independent opinion

on the messaging and the uptake of messaging from the show; and c) updated the researchers on the ongoing messages in the story.

- **Rapid Audience Assessments** on a quarterly basis involved data collection from about 400 viewers to help shape the future course of the EE program/storyline.
- **Viewer panels** with fixed groups of women (15–34 age group) met on a monthly basis to share their perceptions and feedback on the show.
- **Viewer correspondence analysis** entailed a random content analysis of 100 letters every month.

Good Practices

- **Focus on sustainability: "**Kyunki" was deemed a sustainable project, because the costs for reaching each viewer was 0.70 paise (about 2 cents). For broadcasters, the program could also draw in revenue if marketed well. Its success led to the development of 42 stop-start video episodes based on "Kyunki's" first season to be used for health worker group discussions, called Ammaji Kehthi Hain. Additional follow-ups to the project included a radio adaptation, 10 one-hour thematic films that can be shown on special occasions such as Health and Nutrition Day, and a mobile ringtone based on songs from the show.
- **High-quality media programming:** The close interaction between the message design unit and technical experts ensured technical accuracy. The strategy also featured the use of a message matrix and message takeaway; ideation workshops; and making messages culturally appropriate and relevant. The messages were embedded in the drama itself rather than as a separate component, thus making the EE format more compelling.
- **Robust research:** The use of the varied research approaches described above was helpful in tracking and improving the program. After the first season, the program tweaked messages to improve comprehension. For example, the number of times to get immunized was repeated, and the music and lyrics of the songs were simplified to make them more understandable and hummable.

B. Programs Focused on Safe Motherhood/Birth Preparedness (SM/BP)

Programs Employing a "360" Approach

10. SUMATA Initiative	
Donor: USAID **Implementing agency:** Maternal and Neonatal Health Program/partnership (MNH) of JHPIEGO, CEDPA, and JHU/CCP.	**Good Practices:** • 360 approach • Strong/innovative partnerships • Theory/model as foundation
Duration: 2002–2004 **Geography:** Nepal – Banglung, Lalitpur, Kailali	
Publication/Source: 1. Birth preparedness and complication readiness: a matrix of shared responsibility. Maternal and Neonatal Health Program. Baltimore, MD: JHPIEGO; 2001. p. 12. 2. Measuring the effects of behavior change interventions in Nepal with population-based survey	

results. Sood, S; Chandra, U; Mishra, P; Neupane, S. Maternal & Neonatal Health Program. JHPIEGO. 2004.

Background

SUMATA was a central component of the His Majesty's Government of Nepal's (HMGN) Safe Motherhood (SM) program to improve pregnancy outcomes for mothers and their newborns in the country—SM was part of the overall MNH program in the country, which had been launched in 1999. The goal of the SM component was to improve the policy environment and coordination for SM; increase the quality of SM services; and ensure access to and demand for SM services.

Goals and Objectives

The core goal of the SUMATA Project (translated into Nepali as care, share, prepare) was to increase access to and demand for SM, specifically through:

- A more focused and coordinated policy environment for SM
- Improved quality of MNH services in facilities and communities throughout the country
- The adoption of appropriate MNH behaviors, including increased access to and demand for high-quality maternal and newborn health services.

Target Audiences

The target groups were women, husbands, families, community leaders, and community-based health workers. Initially, the SUMATA initiative was targeted to rural populations; therefore, the baseline situation analysis included only a rural sample. Given the political instability in Nepal at the time of the project, many SUMATA activities could be conducted only in and around district headquarters for security reasons. Therefore messages appropriate for urban audiences were developed.

Process and Strategies

Broadly speaking SUMATA used the following strategies:

- **Robust approach to partnerships,** both with government and civil society**.** The project was implemented with the support of national and local networks and the SM subcommittee to complement and build upon the work of other stakeholders, collaborating with them to develop tools and approaches that could be adopted and scaled up by the government and other agencies as part of the national program.
- **Well-designed SBCC component based on the Stages of Change Theory** as an underlying theory of behavior change. This theory posits that individuals move through stages in the behavior change process from acquiring knowledge, to formulating intentions, to performing behaviors. In the SUMATA context, these stages were denoted as knowledge of the danger signs of pregnancy, knowledge of available and appropriate obstetric services, intention to use services, intention to perform certain actions to prepare for birth (plan for a skilled provider, plan to save money, plan to arrange backup transport if the need arises), and the actual carrying out of these behaviors. The SBCC component consisted of:
    - A robust approach
    - Radio spots, jingles, and dramas; district-level broadcasts of radio vignettes in June 2003

- Print materials such as posters, banners, and "danglers"
- Street theater
- A television drama that aired in July 2003
- *Jeevan Suraksha,* or the Birth Preparedness Package (BPP)[14]
- Local language translation and district-level broadcast of radio vignettes by Nepal Safe Motherhood Program (NSMP) beyond the pilot areas
- Standardization and dissemination of SM/BP messages.

SUMATA Project Results

- Increased comprehension of birth preparedness messages
- Increased knowledge of at least one key pregnancy danger sign
- Increased knowledge of at least one key newborn danger sign

- **A two-pronged capacity-building approach**:
  - Mothers, families, and communities enabled to plan for normal and emergency births by using the BPP
  - Capacity-building for community-based health workers—such TBAs, female community health volunteers (FCHV), and maternal and child health workers (MCHWs)—to promote and use the BPP

- **A matrix that delineated the roles of** policymakers, facility managers, providers, communities, and families in improving maternal and newborn care, and outlined plans and actions that were implemented by each group.

- **Advocacy and social engagement** to build consensus. A national workshop called "Speaking with One Voice" was held in November 2000 and laid the foundation for a unified approach to increasing access to SM health care services and sowed the seeds for an integrated national IEC and SBCC strategy focusing on key behaviors to promote maternal and neonatal survival. It also provided a basis for the development of a SM advocacy strategy and SM messages and informed the development of the *Jeevan Suraksha* (Birth Preparedness Package), designed as part of the SUMATA initiative and used as a tool for both IPC and social mobilization.

Good Practices

- **360 approach:** SUMATA used a multi-pronged communication strategy involving multiple channels to facilitate high exposure to messaging.

- **Strong/innovative partnerships:** SUMATA worked through alliances and partnerships using a matrix approach to synergize efforts and standardize consistency in messages of all partners at all levels.

- **Theory/model as foundation:** the SBCC approach used Stages of Change Theory to determine how to target people at the stage they were to develop an integrated SBCC strategy as well as an advocacy strategy, which served as guides to implement the program.

11. Nepal Safer Motherhood Program (NSMP)	
Donor: DFID (then known as ODA) **Implementing agency:** Govt. of Nepal,	**Good Practices:** • 360 approach

[14] Detailed as an independent case study

Options Consultancy Services Ltd., UNICEF, UNFPA, USAID, DFID, GTZ and WHO.	• Communication planning cycle • Extensive provider training/support • Focus on sustainability
Duration: 1997–2004 **Geography:** Nepal – Baglung, Kailali and Surkhet	
Publication/Sources: 1. "Artistry of the Invisible": Evaluation of 'Foundation for Change' – a change management process. Hodgson, R; Badu, K; *et al*. DFID July 2003. 2. Challenging 'Ke Garne': Experiences of the Nepal Safer Motherhood Project. Joyce Abbatt. 1999, Options Consultancy Services. 3. Community mobilization for safe motherhood (Protocol). Gazi, R; Hossain, S.S; Zaman, K; Koehlmoos, T.P. Cochrane Database of Systematic Reviews. Issue 4 2011. CD009091. 4. Increasing Access to Essential Obstetric Care: A Review of Progress and Process. Thomas, D; Messerschmidt, L; *et al*. October 2004. DFID. HGMN Safe Motherhood Program. 5. The Nepal Safer Motherhood Project: A Model for Change (article). Wilkinson, D; Cole, M; Clapham, S; Pradhan, Y.V. September 2004. 6. The Nepal Safer Motherhood Project (NSMP): A Model for Change. David Wilkinson. Family Health Division, Department of Health Services, Ministry of Health, HMGN; Options, DFID. March 2003. 7. Qualitative Investigation of NSMP's Radio Program Launched in Surkhet District. Adhikary, K. n.d.	

Background

Nepal is a country of rich cultural diversity within which the majority of communities are made up of highly stratified, ethnically mixed, and geographically dispersed populations (thanks to the difficult terrain). NSMP was created to address this challenge in promoting SM.

Goals and Objectives

The goal was to reduce maternal mortality by increasing utilization of and access to quality EmOC.

Target Audiences

The target audience was pregnant and recently delivered women.

Process and Strategies

NSMP addressed the widely dispersed and diverse population through two broad program components:

- **Improving service provision**. This included bolstering the capacity to provide basic and EmOC, ranging from hardware aspects to "software" aspects such as improving the performance of technical and managerial personnel, as well as enhancing their morale, motivation, and pride. The latter was addressed through adopting Foundations for Change (FFC), a training package to improve the management and implementation of SM programs, organizations, and stakeholder groups; district hospitals; district administrations; line agencies; NGOs; and communities. An integral part of the package is developing individuals' sense of self potential and ability to change.

- **Increasing access to services.** This was through BCC (radio, street drama, print materials), and addressed practical issues such as emergency transportation and funding schemes. The project was implemented through 56 partners and was overseen by district Reproductive Health Coordination Committees (RHCC).

Important strategies that promoted access to services:

- **Developing a national IEC strategy** (2002–2007) in collaboration with the USAID Maternal and Neonatal Health Program. The program worked with its implementing partners to develop a wide range of SBCC materials and methods, which partners have used to disseminate key SM messages at the community level through public events, such as street dramas, puppet shows, rallies, and song competitions. To complement and reinforce the messages, the project produced a series of printed materials, such as flipcharts, leaflets, diaries, and calendars.
- **Working with a range of government stakeholders,** including 20 line departments of the government and 27 NGOs from nine districts.
- **Developing and implementing district-level communication plans/programs based on the national communication strategy for safe motherhood**. By working with the District Public Health Office (DPHO) and District Education Office (DEO), locally developed teaching materials on SM were included in the DEO's Non-Formal Education (NFE) program, providing an excellent forum for women to discuss issues openly, share experiences and ideas, and raise their awareness in a non-threatening environment. Similarly, working with local health workers, mothers' groups, and mother-in-law/ daughter-in-law gatherings proved to be successful in discussing traditionally accepted but harmful behaviors and practices.

NSMP Project Results

- Increase in met need for EmOC
- Improved intra-family communications and support for pregnant and newly delivered women
- Improved leadership, congenial atmosphere, and performance-based incentives
- SM mainstreamed into other health activities
- Increase in VDCs involved in SM
- Improved quality of services, record keeping, and relations with the community

- **Working with selected partners to produce a weekly radio show** called 'Aama' (Mother), broadcast on two regional and one local FM station. These episodes followed the themes of the National Safe Motherhood IEC strategy, as well as highlighted local issues and promoted the obstetric services of local district hospitals. The programs invited listeners to send in questions that were answered on-air by local experts. An additional three videos on SM were produced and used by partners to disseminate key messages at community events such as rallies and competitions.
- **Collaborating on the development and production of printed and audiovisual materials** with the SUMATA national communications initiative (see Case Study #10), implemented in partnership with HMGN National Health Education, Information, and Communication Centre (NHEICC), and the Maternal and Neonatal Health Program (MNH).
- **Disseminating project experiences and lessons learned** through a well-designed dissemination strategy.

Good Practices

- **360 approach:** The project was implemented by 56 partners working on improving service provision and increasing access. SBCC activities included a weekly radio magazine and three videos, print materials and public events. Developing and implementing locally relevant

programs such as the women's discussion forum was very effective in raising community awareness of SM.

- **Communication planning cycle:** Following the development of a National IEC Strategy (2002–2007) and a wide range of materials and methods, district-level communication plans and programs were developed based on the national strategy and then implemented through local partners.
- **Extensive provider training/support:** The project employed participatory approaches to problem solving, which helped it identify and strategically address critical points of resistance, including the prevailing *ke garne*[15] mindset. It also fostered ownership and involvement of key stakeholders using the "whole hospital approach" and by training entire teams of staff ensured that there was a body of people committed to making the change sustainable.
- **Focus on sustainability:** NSMP strengthened existing district institutional coordination structures to institutionalize SM, namely RHCC and Safe Motherhood Forums (SMF). NSMP demonstrated the value of RHCCs/SMFs, encouraged their ownership of safe motherhood issues, and mobilized local political commitment. The legacy of NSMP also included contributing to the development of key national strategies such as the one for communication, national quality of care guidelines, a monitoring system for EmOC, legalizing abortion thus preventing maternal mortality/morbidity, and founding the national SM subcommittee—a crucial platform for debate on policy issues.

Program Focused Primarily on Community-Based Interventions (CBI)

12. Advocacy for Safe Motherhood	
Donor: Multiple, including the McArthur Foundation, Swedish International Development Agency (SIDA) **Implementing agency:** White Ribbon Alliance of India (WRAI)	**Good Practices:** • Focus on sustainability • Strong/innovative partnerships
Duration: June 1999–ongoing **Geography:** National, with some focus states such as West Bengal, Orissa, Madhya Pradesh, Rajasthan, Maharashtra, and Uttar Pradesh	
Publication/Source: 1. Catalyzing Collective Action for Saving Women's Lives. Motihar, R and Gogoi, A. White Ribbon Alliance for Safe Motherhood, New Delhi, 2009.	

Background

India accounts for 25 percnet of the world's maternal deaths (about 70,000 per year). India's maternal mortality ratio is 221 maternal deaths per 100,000 live births. Two-thirds of these deaths occur in nine states: Bihar, Jharkhand, Orissa, Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Uttaranchal, and Assam. The White Ribbon Alliance of India (WRAI) was, therefore, launched in 1999 as a broad-based network to address the issues of SM.

Goals and Objectives

The goal of the program was to increase global grassroots advocacy and government accountability to make motherhood safer.

[15] Roughly translated as: "what to do?" and implying "don't give yourself a headache because nothing can change"

The objectives of the program included:

- Raise awareness among citizens, international NGOs, national NGOs, and governments of the need to ensure safe pregnancy and childbirth.
- Build alliances through wide-ranging, inter-sectoral partnerships with non-traditional groups (for example, teachers and religious organizations), recognizing that a large and united effort is critical to effect change.
- Act as a catalyst for action to address maternal deaths and sustain an ongoing SM effort.

Target Audience

The target audiences were international and national NGOs, governments, and the general public, especially women of child-bearing age and their families and communities.

Process and Strategies

The WRAI is affiliated with the international White Ribbon Alliance, which includes the following key strategies:

- Identifying and sharing applicable knowledge and best practices
- Implementing innovative campaigns through partnerships and networks
- Advocating for policy changes
- Disseminating messages and information through mass media
- Mobilizing political figures and policymakers
- Mobilizing celebrities and champions to expose the issue
- Working at the community level using social mobilization models
- Employing three key ongoing accountability mechanisms to increase awareness and commitment to the topic:
  - **Public hearings:** Create a platform for women to present grievances and demands to public health officials and elected representatives. They are attended by the media, civil society representatives, and elected officials. As a result, maternal health issues are often reported in the local news; the Chief Minister of Orissa declared that women's SHGs will be involved in monitoring of maternal health programs (for example, SHGs formed a committee to track bribes taken by MHC providers).
  - **Verbal autopsies:** Serve as formal documents that are used as an advocacy tool for media and elected representatives. They help to alert officials to gaps in health services.
  - **Checklists for monitoring health facilities and services:** The findings from these checklists are used to address a range of gaps such as the absence of life-saving

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skills and drugs with ANMS and the absence of electricity or phones.

Good Practices

- **Focus on sustainability:** The alliance created engagement and action for SM by working with existing stakeholders, facilitating information equity across them, promoting evidence-based best practices and innovations and events, facilitating cross-sectoral dialogue, pooling technical resources, and building political and social will. WRAI followed up on this heightened awareness and momentum by lobbying the government to declare an annual National Safe Motherhood Day.
- **Strong/innovative partnerships:** Organizations within the network were used to promote and share evidence-based best practices for SM, and for conducting advocacy for the declaration of a National Safe Motherhood Day. This included working in collaboration with the government, engaging elected representatives, promoting celebrities as champions, and launching the global campaign "Deliver Now" to conduct outreach to youth.

13. The Birth Preparedness Package (BPP)	
Donor: USAID **Implementing agencies:** Ministry of Health and Population, JSI Research & Training Institute, Inc., Engender Health, JHPIEGO, JHU/CCP, and Save the Children USA	**Good Practices:** • Extensive provider training/support • Focus on sustainability
Duration: 2005–2007 **Geography:** Nepal – Banke and Jhapa districts, in Kanchanpur from July 2006	
Publication/Source: 1. Process Evaluation of a Community-Based Intervention Promoting Multiple Maternal and Neonatal Care Practices in Rural Nepal. McPherson, R; Tamang, J; Hodgins, S; *et al*. *BMC Pregnancy and Childbirth* vol. 10 issue 31 June 2010. Epub. 2. Community-Based Maternal and Neonatal Care Program. Summative Report on Program Activities and Results in Banke, Jhapa, and Kanchanpur Districts from September 2005-September 2007. USAID. Johns Hopkins School of Public Health. Nepal Family Health Program.	

Background

Studies of hospital and community-based mortality data suggest that the major causes of neonatal death in Nepal include pre-term birth, infection, hypothermia, and birth asphyxia. Many maternal and newborn deaths can be averted through changes in household-level practices regarding delivery and newborn care.

The BPP, which is now referred to as community-based maternal and newborn care (CB-MNC) program, has a long and somewhat complicated history in Nepal. It was initially launched under the Maternal and Neonatal Health Program as part of the SUMATA initiative (see Case Study #10) in the districts of Lalitpur, Banglung, and Kailali starting from 2002. This was followed by another program called the Jeevan Suraksha under the Ministry of Health and Population (MoHP), launched in March 2002. In 2005, the MoHP, with support from the USAID Nepal Family Health Program (NFHP), began to implement a modified and integrated version of the Jeevan Suraksha—CB-MNC program—in three districts: Banke, Jhapa, and Kanchanpur.

Goals and Objectives

The BPP program aimed to improve the health and survival of mothers and newborns by increasing knowledge among community members and the practice of beneficial household behaviors, and by increasing the use of MNH services. A specific objective was to promote active preparation and decision-making for births, including pregnancy/postpartum periods, by pregnant women and their families.

Target Audience

The target audiences were mothers of newborns, pregnant women, and their families.

Process and Strategies

Broad components of the program included:

- Health education and counseling with pregnant women and household decision makers during the antenatal period, primarily by FCHVs[16]
- Strengthening existing health services
- Postpartum home visits by FCHVs

The BCC component of the program included:

- Promoting behavior change through demand generation focused on key messages through IPC by FCHVs, who are the backbone of the country's health outreach and education system.
- BP programs addressing the three delays to care-seeking for obstetric emergencies: delay in recognition of problem, delay in seeking care, and delay in receiving care at facility.
- Developing a birth-preparedness/complication readiness (BP/CR) matrix to be used by SM partners and stakeholders. This matrix was previously used in Nepal as part of the SUMATA initiative.
- Developing materials based on the BPP framework, including:
    - Guidelines for CHWs to use for structuring IPC with clients.
    - A flipchart to be used by the CHWs.
    - Key chains (a symbol of women's empowerment in Nepal) which were given to each pregnant woman to promote MNH. They consist of laminated cards that repeat the messages and illustrations contained on the flipchart.

Messages in the flipchart and key chain focused on four areas of birth planning: ANC; care for the mother and newborn during and after delivery; danger signs in women and newborns; and financial and logistical preparations for pregnancy, delivery, and the postnatal period.

[16] The MoHP established the FCHV program in 1988 to strengthen outreach and coverage of government health services. FCHVs are unpaid, from the community, and cover about 100–150 households, and spend about 5 hours/week conducting health promotion activities, dispensing commodities and limited case-management.

The flipchart and key chain were pre-tested for understanding with both literate and illiterate women. The BPP was implemented by CHWs comprising FCHVs, TBAs, MCHWs, and supporters. The project held a two-day training of mobilizers and supporters on counseling techniques and use of the BPP tool, and supporters received three days of additional training on the technical aspects of SM.

BPP/CB-MNC Project Results

- Increase in number of women served by FCHVs
- Increased utilization of health services by women and newborns
- Increased use of products distributed by FCHVs (for example, iron folic acid (IFA), deworming tablets)
- Improved knowledge and healthy practices due to message exposure
- Reduced inequities in healthcare utilization and delivered benefits

Although all three districts had a basic "core" package of CB-MNC content based on the BPP,[17] there were important inter-district differences in CB-MNC content. Banke district alone had an initiative to provide misoprostol to pregnant women prior to their delivery to give some protection against postpartum hemorrhage (PPH). PNC visits in Jhapa district were guided by a specially designed job aid—the BPP colored cards. Although CB-MNC in Kanchanpur was conducted without the BPP key chain and implemented with a complementary low birth weight (LBW) intervention delivered under ACCESS/ USAID.

Good Practices

- **Extensive provider training/support:** To complement strengthening of existing health services and improve counseling of pregnant and postpartum women by FCHVs, the project created a BPP and corresponding job aids for the community providers. Personnel reported that the BPP was helpful in arranging existing messages into a coherent framework. The pictures in the registers were designed to be in sequential order to guide them and because many of the pictures in the registers were identical to corresponding pictures in the BPP keychain, it allowed illiterate FCHVs to use the registers.
- **Focus on sustainability:** The project strengthened existing services and health systems to improve sustainability. Because the program was designed and implemented through existing health systems, it was cost effective, with high degree of potential for scale and sustainability. In particular, the role of FCHVs was significantly enhanced, and despite the increased workload, many of them seemed to value these additional responsibilities because it increased their social status in their communities.

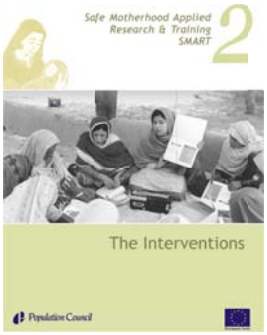
14. Safe Motherhood Applied Research and Training (SMART)	
Donor: European Union **Implementing agency:** Population Council	**Good Practices:** • Adaptation of materials to local context • Extensive provider training/support • Strong community–health services linkages
Duration: 2002–2006 **Geography:** Pakistan – Two intervention sites in Dera Ghazi Khan and one control site in Layyah	
Publication/Source: 1. Safe Motherhood Applied Research Training (SMART) Reports 1 – 4, Population Council, 2006.	

[17] Includes both facility-based and community-based elements through which a set of core services are delivered: counseling, dispensing, commodities, documentation, assessment, and referral as needed.

Background

The vast majority of maternal deaths are attributed to delays in getting medical care in the face of obstetric complications, as described in the "three delay" model. The first delay is the delay in making the decision to seek emergency care; the second delay is in getting the mother to a proper emergency care facility; and the third delay is in obtaining appropriate care at the health facility.

Goals and Objectives



The overall goal of SMART project was to develop, implement, and evaluate health and CBIs to increase the utilization of RH services and to reduce maternal mortality and morbidity in the project implementation site. The principal objective was to test the hypothesis that reducing the first, second, and third delays through a concerted effort is significantly more effective than reducing just the third delay alone.

Target Audiences

The target audiences were health care providers at the community and district levels, community members (women of child-bearing age and their family members), and transporters/drivers.

Process and Strategies

Careful attention was paid to the needs of the largely rural environment with limited resources, poverty, and cultural restrictions on women's decision-making authority and mobility.

The first two delays were addressed through *CBI*, while the third delay was addressed through *health services interventions* (HSI). The SMART project was implemented in three sites (two intervention sites in Dera Ghazi Khan and one control site in Layyah district) and studied the impact of two different interventions: one at the community level and the health facility level combined (CBI+HSI); and the other at the health facility level alone (HSI), in comparison with each other and with the control area.

The SMART project tested a model of MNC consisting of an intensive community-based intervention, supplemented by refresher training of static facility care providers. Following were specific components of the project:

- **General Training:** Training on the client-centered approach (CCA) was given to all of the health care providers participating in the SMART interventions to help improve their IPC skills. The goal was to improve the client-provider interaction, empower clients through information exchange, and involve them in choosing solutions.
- **Specific Health Provider Training:** Community health services were upgraded by training female health workers and *dais* (key people performing most of the deliveries in Pakistan, but have no formal training). On the district level, health providers from the district health departments and doctors in private practice were trained. Managers of health and population/welfare departments within public health facilities were also trained in client-centered health service provision, leadership, and supervision.
- **Community Member Training:** Different groups of men and women

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from the community were trained in MNCH issues. Village health committee members received a one-day orientation on SMART activities and their role in reducing maternal and neonatal mortality and morbidity. Facilitators were trained to conduct support groups to raise the awareness of community members regarding RH issues using an information/education booklet and audiocassette developed for this purpose. Drivers and transporters were identified and sensitized to the various obstetric emergencies that can occur so that they would be able to help women who needed to reach a health facility in the event of such an emergency. Their orientation included meeting the staff of both public and private health facilities so that they would know where to go and whom to contact.

- **Community Engagement:** To provide in-depth information to child-bearing women and their families, and to mobilize communities to support MNH activities, the project embarked on an integrated set of activities, including holding intensive support groups for women and men, and organizing health communities with stronger linkages to transportation options and the formal health system. Establishment of VHCs, including facilitators, emergency funds, cashiers, and transporters were important steps in this process. Different strategies were used to educate men and women in light of challenges related to cultural differences, family feuds, residential status, and caste systems.
- **Behavior Change Communication (BCC):** Materials were developed to inform and educate people about how to reduce delays in treating complications faced during pregnancy, delivery, and the postpartum period, for mothers and newborns. Formative research prior to developing the materials took into account the MNH terminology in the community, as well as the knowledge and beliefs of women and men of reproductive age. A draft set of BCC materials was prepared, pretested, and then revised according to the pretest results.

To make support groups effective, printed as well as audio materials (for illiterate populations) were used both to guide the discussions and to serve as reference materials for the communities and mothers in particular. These materials included the following:

- **A detailed pictorial instruction booklet** with seven chapters, each of which featured the story of a particular woman and covered topics such as nutrition, ANC, danger signs, safe delivery practices, postpartum care, neonatal care, and FP methods.
- **A matching audiocassette** was based on actual stories collected from local women during formative research. The audiocassette, lasting 1 hour and 20 minutes, combined the stories with the messages given in the booklet. The audio was available with either male or female narrators for use during women's and men's group meetings.
- **An ANC pictorial card** was designed for pregnant women to keep during their pregnancies as a reminder of what to do and what to watch out for. The ANC care card contained a panel for each of the seven main topics in the booklet, with four pictures on each panel illustrating a single message.

Good Practices

- **Adaptation of materials to local context:** The BCC materials developed were based on formative research and pretesting. The materials were gender-adapted to emphasize empowerment of women and involvement of men to encourage health-seeking behaviors and accessing of service; a specific example was creating both a male- and a female-narrated audiocassette to accompany the pictorial booklet. In addition to the results demonstrating the

effectiveness of the materials, feedback from the target audience about the materials was uniformly positive.

- **Extensive provider training/support:** Training of various levels of health providers with multi-faceted CBI packages provided a positive impact on improving pregnancy and related outcomes, including perinatal mortality, in communities where they work. These activities were well received in the communities by both women and men, and were shown to have substantial effects on community knowledge and practices. Improving health providers' interactions with clients through CCA increased the confidence of the women in the health facilities.
- **Strong community–health services linkages:** Building a link between *dais* and female health workers, and between *dais* and health facilities, brought about better management of MNCH. Establishing emergency obstetric and neonatal care funds (EmONC-F) and establishing emergency obstetric and neonatal care transport systems (EmONC-TS) decreased delays in the decision to seek timely care. Providing a phone card with emergency numbers and addresses to the VHC members improved community involvement in MNCH issues of the village.

C. Programs Focused on Diarrhea Prevention (ORS, POU Water Disinfection, Sanitation)

Programs Employing a "360" Approach

15. Saathi Bachpan Ke (SBK)	
Donor: USAID **Implementing agency:** ICICI Bank under the bilateral Program for Advancement of Commercial Technology – Child and Reproductive Health (PACT-CRH)	**Good Practices:** • 360 approach • Focus on sustainability • High-quality media programming • Robust research • Strong/innovative partnerships
Duration: 2002–2007 **Geography:** India – Urban areas of eight Hindi belt states: Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Delhi, Jharkhand, Uttarakhand, and Chhattisgarh.	
Publication/Source: 1. Saathi Bachpan Ke: Promoting Diarrhea Management through the Private Sector in Urban North India. Program Report. USAID, ICICI Bank, PSP-One.	

Background

A 2000 estimate suggested that nearly 16 percent of all deaths in children under 5in India could be prevented through the use of ORS. According to the National Family Health Survey (NFHS) in 1998–1999, although awareness of ORS was 62 percent nationally, usage was low, at 27 percent.

The implementing agency was ICICI Bank under the bilateral Program for Advancement of Commercial Technology – Child and Reproductive Health (PACT-CRH). Technical assistance was provided by the Commercial Marketing Strategies (CMS) project till 2004, and then by the Private Sector Partnerships (PSP)-One until July 2007. The project was re-launched in 2010 under the name of Market Based Partnerships for Health (MBPH). However, this case study is based only on documentation from the PACT-CRH program, since it is not currently available for the MBPH.

Technical advisory group consisted of experts from the All India Institute of Medical Sciences (AIIMS), IAP, World Health Organization (WHO), USAID, and AED. The steering committee had representatives from ICICI Bank, CMS/PSP-On, and the communication agencies.

Goals and Objectives

The overall goal was to increase the market for ORS. Specific objectives were to increase sales of ORS, and to increase the use of ORS as the first-line of treatment for childhood diarrhea.

Target Audiences

- **Caregivers/mothers, fathers and other family members of households with children up to the age of 5:** Until 2005, the target group consisted of middle and upper-income households in socio-economic class (SEC) A to D who could afford to buy ORS from the market. In the later phase of the campaign, the focus shifted to lower-income households in SEC D and E, the most vulnerable segments that comprised 45 percent of the target population and had lower levels of knowledge on diarrhea management.
- **Health care providers:** An analysis of prescription audit data indicated that regardless of their qualifications, only 18 percent of doctors prescribed ORS, usually preferring other medicines such as antibiotics and anti-diarrheals (ORG, July 2000). Research also indicated that the indigenous system of medical practitioners (ISMPs) treated almost 43 percent of all children under 2 who were suffering from diarrhea, and hence were a key target group.
- **Pharmacists/chemists:** They were especially important because they stock and display WHO-formula ORS brands and could advise on correct preparation and usage.

Process and Strategies

The overall approach was to generate demand through an intensive communication and marketing campaign, along with strengthening diarrhea management and supplies by building the capacity of the private sector.

The project applied an **integrated and multi-pronged marketing approach** that included:

- **Community outreach and innovation** that led to many long-standing changes in ORS use, thanks to the advocacy, outreach, and communication activities. These included ORS Day events/celebrity activities.
- **Public relations** through Corporate Voice Weber Shandwick (CVWS), which aimed to build, sustain, and increase media support for the campaign.
- An **intensive communication campaign** executed by McCann HealthCare, one of India's leading advertising agencies, involving several TV and radio spots, media activities, and related materials. In 2006, the campaign extended into the Saathi Bachpan Ke (Friends of Childhood) Complete Home Diarrhea Management (CDHM) campaign.
- **Policy advocacy** to shift to a single WHO-approved formula of ORS and to garner industry and health care provider support for this shift. In 2005, after supporting policy advocacy for a shift to the WHO-approved ORS formulation, the program helped transition the market to the single-dose, reduced-osmolarity ORS, which was approved by the Drug Controller of India.

- Working with health care providers, including **training of ISMPs**. The campaign was able to open new markets and include new providers for diarrhea management, such as ISMPs. ISMPs were typically not considered by most pharmaceutical and other commercial-sector players, since ISMPs were never adequately trained or supported for their roles as healthcare advisors for common ailments.
- Motivating general practitioners and pediatricians through the IAP to prescribe and recommend ORS for children; and strengthening retail availability and promotion of prescriptions.
- **Institutional partnerships** with a range of stakeholders including National Railways, Mother Dairy, Delhi Transport Corporation, Central Schools Association, National Cadet Corps, and Department of Posts. This helped to multiply the visibility and reach of the program and its messages. In 2007, the program designed and piloted communication and promotion strategies and prototypes that could be used by the GOI, private sector actors, and others to introduce zinc therapy.
- **Use of consumer/market research** as part of the communication planning cycle and to help plan the campaign. Specifically, the research was used to develop, test, and monitor all key interventions, creative advertising items, merchandising, training, retailing, and contact programs, and to track knowledge and attitudes among providers as well as ORS sales.

The SBCC campaign was composed of three key elements:

- Mass media involving PSAs and in-serial promotions.
- Teams of trained promoters doing door-door IPC, and reaching 200,000 caregivers every year. IPC was complemented with step-by-step demonstrations on ORS preparation and usage, and providing sample packs and leaflets on diarrhea management.
- Street theater in media-dark areas that depicted real-life situations and fostered understanding and adoption of five new behaviors. Theater performances covered 20 clusters in each of 27 towns.

***Saathi Bachpan Ke* Project Results**

- Increased awareness of the need for exclusive breastfeeding of children up to six months
- Increased awareness of need to increase nutrition intake after diarrhea
- Increased use of ORS for children with diarrhea in the past two weeks
- Claimed use of soap for hand washing on at least two out of four critical occasions in last 24 hours remained high
- Increased annual sales of ORS

Good Practices

- **360 approach:** The program employed advocacy to decision-makers, mass media, in-home IPC about ORS, including demonstrations, local street theater, and training of health care providers, including the private sector and indigenous providers.
- **Focus on sustainability:** The project helped to institutionalize a National ORS Day, which is now conducted annually across all regional chapters by the IAP. The NRHM committed resources to support communication efforts related to diarrhea management, including use of ORS.
- **High-quality media programming:** A significant mass media component, with a media plan developed by a professional firm using highly sophisticated tools, helped to increase the reach and visibility of the campaign. This was complemented by strategic and professional news media advocacy, which helped to increase the visibility and salience of the issue overall and of

the campaign in particular. Extensive negotiations with media channels ensured that free airtime was provided for the campaign spots.

- **Robust research:** The program used comprehensive consumer and marketing research as part of the planning cycle and to track results overtime. The tracking data provided timely information that was used to facilitate mid-course corrections, and to respond effectively to changing realities and needs in the larger environment, as well as strengthen policy advocacy. Moreover, the category campaign dedicated significant resources to consumer and market research and analysis of the overall market. This benefitted manufacturing partners, who typically did not invest in such research and analysis. Sharing market research insights also provided an entry point for discussions about campaign with partners who otherwise were reluctant to share these details.
- **Strong/innovative partnerships:** Collaboration with private sector organizations resulted in increased commercial sector investment in ORS promotion and launch of new brands. The project also successfully leveraged media and marketing funds totaling about Rs. 6 crores ($1.4 million) over the life of the project. Private sector partners perceived a clear business benefit in being associated with USAID, and their credibility with doctors increased. Promotion of WHO-ORS was seen as a social effort, thus giving it additional credibility.

Programs Focused Primarily on Community-Based Interventions (CBI)

16. The POUZN Project	
Donor: USAID **Implementing agency:** AED, PSI **Private sector partners:** Safewat (chlorine liquid); Medentech Aquatabs (chlorine tablet); Hindustan Unilever, Ltd., (HUL) Pure-it Water Filter	**Good Practices:** • Adaptation of materials to local context • Detailed audience segmentation • Focus on sustainability • Strong/innovative partnerships
Duration: 2005–2010 **Geography:** India, Tanzania, and Indonesia. In India, the project was implemented in Uttar Pradesh, in Kanpur, Lucknow, and Allahabad cities, and the villages of Basti, Faizabad, Ambedkar Nagar and Sultanpur.	
Publication/Source 1. Promoting Zinc and ORS for the Management of Childhood Diarrhea in India: A Research Brief. 2. Operation *Jal Mitra*. Documentary. Available from: www.youtube.com/watch?v=T7x-wS0hXDo	

Background

Poor water and sanitation conditions that result in diarrhea/dehydration account for a large proportion of infant/child mortality and morbidity. Programs that target individual and family behaviors related to clean drinking water and hand washing, together with the promotion of home-based diarrhea management through ORS/zinc, are crucial. It is equally important to consider wider water-sanitation approaches to improve the external conditions that increase risk for such diseases.

Goals and Objectives

The project aimed at tackling diarrhea, which accounts for approximately 500,000 deaths every year. Its goals were to increase awareness of contaminated drinking water, promote the use of point-of-use (POU) water disinfection, and integrate zinc treatment with ORS for the treatment of diarrhea.
The project objectives were to:

- Increase the use of POU methods/products among the urban and rural poor by promoting awareness, acceptance, availability, and affordability of the products.
- Increase awareness on multi-point water contamination and to ensure safe drinking water at the point of used.
- Test program models to produce scalable, sustainable, and cost-effective strategies for increasing use of POU water-purification methods and devices among the poor.

Target Audience
The target audience was urban and rural poor populations.

Process and Strategies

- The project featured **partnership building with a range of stakeholders** to ensure the availability of low-cost POU devices and their promotion in slum communities. Major partners included: suppliers of POU products (for example, liquid chlorine, chlorine tablets), commercial filter manufacturers; and NGOs with ongoing activities in urban and rural areas. The project's public–private partnership ensured that POU products, to decontaminate water, were available to the community at a cost-effective price (NGOs would buy it from the private sector at Rs. 15 for 30 tablets, and sell it to the community at Rs. 30. This would be the average cost per month per family). This facilitated the "three As"—accessibility, affordability, and availability—while providing financial incentives for community-based distributors. These are important first steps to long-term sustainability.
- The **communication strategy** involved a set of simple, clear, and actionable messages promoting key behaviors: drinking unclean water can be fatal; thousands of children die every year due to diarrhea and dehydration from unsafe water; and water can be made clean and safe to drink through boiling, solar water disinfection, and using POU products.

- These messages were reflected across a **range of communication materials**, which were carried in attractive bags for NGO community workers. The community workers conducted intensive door-door outreach using simple pamphlets, flipcharts, and most importantly, water testing kits that proved to be the centerpiece of changing people's behaviors.
- **Other communication efforts** included regular meetings and follow-ups with community members; innovative use of IEC materials and promotional events such as having stalls at village 'haats'; product training for project staff; and community demonstrations by private sector partners.

- **Stickers for use in homes** proudly declared "Our family drinks clean water, our health is safe," thus conferring a degree of status on those who had changed their behaviors. A range of calendars, posters, playing cards, and brochures for service providers detailed important messages on ORS/zinc combination treatment for diarrhea and dehydration.

Good Practices

- **Adaptation of materials to local context:** There was a range of simple focused materials produced. The home testing kits were a powerful behavior change tool because they showed, in real time, how contaminated people's water was. The project quickly discovered that a solution (in the form of chlorine) should be offered immediately after highlighting this problem. Village "haats" or market-based activities were effective tools in creating awareness about water treatment.
- **Detailed audience segmentation:** The project ensured that lower socio-economic segments of the population were made aware of having multiple options for water treatment and for preventing diarrhea. Penetration increased dramatically after chlorine tablets and liquids were introduced during the pilot.
- **Focus on sustainability:** Combining financial incentives for distributors with affordability, availability, and accessibility for the community laid the cornerstone upon which a self-sustaining program could be built.
- **Strong/innovative partnerships:** The public–private partnership ensured that POU products were available and affordable for the community. BCC was accompanied by relevant products and services that were affordable, available, and accessible. By working simultaneously on generating demand and ensuring supply of chorine liquid/tablets through CHWs, the project was able to achieve significant impact and behavior change. In addition, NGOs were trained to become effective product demonstrators and micro-distributors.

17. Community-Led Total Sanitation (CLTS)	
Donor: DFID Municipal Corporation of Kalyani township outside Kolkata **Implementing agency:** Kolkata Urban Services for the Poor (KUSP) through the Kalyani Municipal Corporation	**Good Practices:** • Focus on sustainability • Participatory approaches • Theory/model as foundation
Duration: 2005–2007 **Geography:** India – Slums of Kalyani township, outside Kolkata	
Publication/Source: 1. Community Led Total Sanitation in Slums of Kalyani Municipality under Kolkata Urban Services for the Poor (KUSP). Lessons Learnt and Outcome of the Sharing Workshop on CLTS held on 26th May 2006 at Kalyani. Dr. Kamal Kar. 2. How Community-led Total Sanitation made Kalyani an ODF city. Dr. Kasturi Bakshi. PowerPoint Presentation. 3. Urban Community Led Total Sanitation (CLTS). Case study of Kalyani Municipality in Kolkata, India. Goswami, S and Bakshi, K. PowerPoint presentation 2009.	

Background

Community-Led Total Sanitation (CLTS) involves participatory community engagement exercises starting with community groups going on neighborhood walks to observe the consequences of open defecation.

This exercise is designed to trigger feelings of disgust, shame, and fear, but ultimately lead to self-respect and prompt a realization of the negative consequences of open defecation on health, environment, and the economy (for example, chronic illness, poor drinking water quality, workdays lost, medical expenses, and consequent impact on livelihood). This, in turn, prompts individuals and the community to take collective local action to reduce open defecation.

The Government of India's Total Sanitation Campaign (TSC), launched in 1999, has been instrumental in driving up the number of ODF villages through performance-based incentives and national awards, such as the Nirmal Gram Puraskar (NGP). The success of CLTS in rural settings has been more than amply demonstrated; its application in urban scenarios, however, is more challenging and recent, hence the inclusion of this case study.

Goals and Objectives

The goal of the project was to create an ODF township through the use of a CLTS approach. Kalyani, a township near Kolkata, has a population of 100 million and a total of 52 slums. Many of the slums' inhabitants are migrants, especially from Pakistan and Bangladesh. Although some of the slums are more recent, some are as old as 50 or 60 years. Most homes do not have toilet facilities, but even the ones that have toilets practice open defecation.

Target Audiences

The target audience was families and individuals living in the slums in Kalyani Township, near Kolkata.

Process and Strategies

- The idea of CLTS was introduced to the council members of Kalyani as a means of mobilizing political commitment and resources. The council members were persuaded to start a pilot project in five slums. The major objectives of this pilot were to explore the possibilities of introducing community-led development initiatives, with a special focus on public health issues such as environmental sanitation, elimination of open defecation, and solid waste disposal.
- The pilot project started with sensitizing and introducing CLTS to elected municipal council members and all department heads of the municipality, local NGOs/CBOs, health workers, and community leaders. It was made clear that increasing the number of toilets and toilet models was not the goal; rather, the goal was to change behaviors and achieve ODF status.
- The project conducted hands-on CLTS with NGOs and CBOs, followed by development of field facilitators. Participatory tools were used extensively, and it was made clear that there would be no external subsidies. A CLTS team consisting of eight female health workers met weekly to discuss ongoing problems and find solutions to help sustain ODF status. Based on their suggestions, new toilets were constructed in the township, and new houses have in-built toilets.
- The project introduced the concept of sanitary toilets costing a mere Rs. 300 to the residents, with the promise that it would reduce medical expenditures if everybody used them, to rally social solidarity. Once community members

saw the pride and increased social status of those with toilets, as well as the reduced occurrence of illnesses in those families, they began to construct their own toilets, and even started to spend more money to get better pans, concrete walls, and good doors for them.

- Additional incentives were provided to slum dwellers, such as giving ODF-slums priority for other development work, such as building roads, water pumps, and drains, and installing solar-powered street lamps. Community leaders from Kalyani were taken on exposure visits to some of the more progressive Mumbai slums. The project also instituted inter-slum cleanliness competitions to engage community members, and maintained behavior change through folk media. Some of the community members formed the Harijan Para Slum Folk Theatre Group and staged street shows to spread awareness of the benefits of sanitation and relief from diseases and open defecation.

Good Practices

- **Focus on sustainability:** As noted above, CLTS leads to scale and sustainability within a community, as well as built-in potential for expansion, thanks to the visible results and "contagion" from household to household within a community as well as from community to community, as they experience the benefits of being open defecation-free.
- **Participatory approaches:** The CLTS approach is based on a series of participatory steps. CLTS engaged communities by first experiencing the consequences of poor sanitation and using a series of specific "triggers" to encourage the community to decide what actions to take. CLTS also established strong linkages between individual action and cumulative, community-level impact, thus reinforcing peer pressure toward sanitary practices. This is because CLTS triggers the community's desire for change, propels them into action, and encourages innovation, mutual support, and appropriate local solutions, thus leading to greater ownership and sustainability.
- **Theory/model as foundation:** The project was based on the integrated model of communication for social change (Reardon). It focused on how social change using community dialogue can lead to collective action and the resolution of a common problem that affects the welfare of the community as a whole and its individual members. The behavioral change needed to ensure real and sustainable improvements is rooted in community engagement for the creation of ODF neighborhoods. For instance, experience showed that as long as even a minority continues to defecate in the open, everyone is at risk of disease. Hence, the continued need for community dialogue.

Programs Focused Primarily on Mass Media Interventions

18. Sesame Workshop India (SWI) – Entertainment-Education for Health and Hygiene	
Donor: Multiple **Implementing agency:** Sesame Workshop India, part of Sesame Workshop	**Good Practices:** • Extensive provider training/support • High-quality media programming • Robust research • Theory/model as foundation
Duration: 2007–present	

Geography: India – On-air program is national, on-ground activities in Chennai, Bangalore, Hyderabad, Kolkata, Delhi, Ahmedabad, Mumbai, and to some extent in Jaipur
Publication/Source: 1. Developing Contextually Appropriate Materials for Rural Areas. Batada, A and Sharma, G. *ARNEC Connections – Inclusive Foundations for Early Childhood: Working Together to Reach the Unreached*. No. 3 2010. p. 24–26. 2. Building Bridges. Sesame Workshop India. 3. Sesame MetLife Final Report, 2011.

Background

This case study looks at a different entry point—children—for addressing some aspects of health, hygiene, hand washing and nutrition. Although this is not an MCH-focused intervention, it has been included to highlight a different approach that has been successful.

Goals and Objectives

The overall goal of SWI is to enhance ECD. SWI does not work directly on MCH or adult target groups.

Target Audiences

The program works with and through children under nine years-old, using them as an entry point to reach secondary audiences, including parents, teachers, and other caregivers such as AWWs.

Process and Strategies

- **TV EE program called *Gali Gali Sim Sim* (*GGSS*)** with its cast of lovable muppets. The program was initially aired on the Doordarshan TV network, but is currently aired on Cartoon Network and Pogo. It reaches both urban and rural populations.

- **On-the-ground campaign featuring mobile community viewing (MCV),** which includes a refurbished hand cart that follows a route map in slums, screening *GGSS* segments and conducting activities with children and caregivers. These activities entertain and educate young children while equipping them with important life skills and knowledge on health, hygiene, and nutrition. The MCV intervention is implemented through 40 NGOs in Chennai, Bangalore, Hyderabad, Kolkata, Delhi, Ahmedabad, Mumbai, and to some extent in Jaipur.

- **In-school program that produces customized educational content for preschool children and their caregivers.** The caregivers are trained through a cascade approach using video training and progressive teaching methodologies. A toll-free number has been established to support the caregivers in conducting relevant activities, such as gathering feedback and collecting survey responses to educational kits. Over the past five years, the organization has developed over 14 educational kits, which have been provided to 7,000 preschool centers in the country.

- **Video-based training modules.** Recognizing the importance of interactive and ongoing capacity-building, SWI began moving to video-based training modules, and introduced phone-based support systems (in Marathi) to facilitate regular technical support to frontline workers. Short (3–4 minutes each) thematic video-based

training modules have been developed, and provide specific action points for the AWWs, such as how to make storytelling more effective. A curriculum-integration document outlines the activities to be conducted by the AWW each day of the week.

Recognizing the importance of scale, SWI expanded to working with the government, especially with the ICDS program, to build the capacity of AWWs. In Mumbai, for example, SWI works with 5,130 AWCs through 29 ICDS projects. One hundred master trainers have been created through a training-of-trainers process; they then train AWWs on ECD using SWI's communication materials.

Good Practices

- **Extensive provider training/support:** Introduction of video-based training modules and phone-based support systems (in Marathi) to facilitate ongoing capacity-building and regular technical support to frontline workers. The technical support is interactive and provides specific action points for the AWWs. This ensures daily and ongoing feedback, facilitating quality improvement, and assurance.
- **High-quality media programming:** It was crucial to have high-quality professional programming content and communication materials that can compete with commercial programs. SWI's software and materials were rigorously pretested and produced in accordance with high-quality benchmarks.
- **Robust research:** SWI made significant and crucial investments in communications research at all stages of the project, and ensured that research was effectively integrated into programming in a timely manner. Early interventions were evaluated by external third-party research using international quality standards of research, with widespread dissemination of results.
- **Theory/model as foundation:** SWI's significant reach and impact testifies to the power of EE and social modeling as an approach to promoting behavior and social change. Because of its huge potential to attract and engage audiences and its use of stories and role models, *GGSS* successfully reached and helped socialize children (as well as their caregivers) on a range of issues, such as decision-making, conflict resolution, and health-seeking behaviors.

IV. Conclusion and Additional SBCC Resources

The review yielded a rich diversity of SBCC interventions, strategies, good practices, and innovations. These interventions have contributed to comprehensive improvements in MNH, SM/BP, and diarrhea prevention. Many of the interventions have gone beyond focusing on individual behavior change to also influence social norms and create supportive environments for safe maternal and child health practices within the family and the community. Several have incorporated participatory assessment and evaluation activities, in keeping with the government's focus on involving communities to take the lead on their health and wellbeing, especially for women, newborns, and children.

Through regular health care examinations and visits during pregnancy, immunization, and awareness of danger signs, mothers (with support from their families and the community) were able to safeguard the healthy development of their unborn babies and their own health. BP/CR interventions were designed to create awareness of and use of skilled providers at birth, increased use of birthing facilities, and awareness of and access to EmOC in case of pregnancy and childbirth-related complications so as to decrease maternal mortality. These interventions also addressed the issue of gender equity, and ensuring that women can participate in decisions related to their pregnancies and birth of their children.

In addition, some interventions focused on increasing the use of ORS, zinc, and water treatment methods and products through awareness, acceptance, availability, and affordability. This should be coupled with improved sanitation and health practices of the overall community to prevent childhood diarrhea, which is a number one cause of death in children under 5.

Most of the interventions reviewed focused on BCC, although a few projects also employed advocacy and social mobilization strategies. The case studies emphasized that attainment of satisfactory maternal and child health outcomes requires a multi-pronged approach that combines rural development, sanitation, and nutrition with the provision of high-quality, accessible, and affordable health services and supplies. It is also clear that programs are most effective when they employ a "360 approach," disseminating mutually reinforcing messages and materials at many levels and through many different channels. Although mass media channels are very popular due to their ability to reach large numbers of people, the review highlighted the power of community media and CBI to bring about substantial improvement in MCH, especially for women in remote and poor settings.

Based on the evidence that MCH cannot be improved in isolation, India's MoHFW is vigorously promoting a comprehensive strategy that addresses reproductive, maternal, neonatal, child health, and adolescents (RMNCH+A) to meet MDGs 4 and 5. Given the importance of reducing infant and maternal mortality on a nation's overall development, the role of interactive, theory-based, research-driven communication to provide comprehensive services to address the health, nutrition, and development needs of children (especially under 6) and mothers is a significant national priority.

The following resources may be helpful to SBCC specialists or program managers who are planning or implementing their interventions:

- **SBCC Toolkit (C-Change Project):** This toolkit includes products and online resources to support training and courses in SBCC. http://c-changeprogram.org/resources/sbcc-toolkit

- **Social and Behavior Change Communication Training for Information, Education, and Communication Officers (IHBP):** This is a one-week training for information, education, and communication officers in India on designing, implementing, and evaluating SBCC programs and campaigns.

- **IHBP Toolkit:** This toolkit was designed as a job aid for information, education, and communication officers in India to provide practical tools and templates assist them in the design, implementation, and evaluation of SBCC programs and campaigns. http://www.ihbp.org//content/sbcc-toolkit

- **SBCC for Frontline Health Care Workers (C-Change Project):** This is a learning package for use in face-to-face workshops with nurses, community health extension workers, and HIV counselors on SBCC and IPC. http://www.c-changeprogram.org/resources/sbcc-frontline-health-care-workers

- **Facts for Family Planning (C-Change Project):** This document presents a comprehensive collection of key information and messages that anyone can use who communicates to others about FP. Although a variety of individuals and groups can use *Facts for Family Planning*, it is primarily for those who communicate to men and women who are seeking information about FP and help in selecting a FP method. http://www.fphandbook.org/factsforfamilyplanning

- **The New P-Process: Steps in Strategic Communication:** This brochure summarizes the strategic communication planning framework developed by The Johns Hopkins University Center for Communication Programs. http://www.jhuccp.org/hcp/pubs/tools/P-Process.pdf

- **Leadership in Strategic Health Communication Workshop:** Every year The Johns Hopkins University Center for Communication Programs holds a three-week workshop in the United States to train SBCC professionals in the steps of designing effective health communication and advocacy strategies. http://www.jhuccp.org/content/leadership-strategic-health-communication-workshop

V. Index of Case Studies by Country

Country	Case Studies
Programs Addressing Maternal and Neonatal Health	
India	#1 (Sure Start), #5 (CLICS), #6 (The Smile Campaign), #9 (Kyunki Jeena Isi Ka Naam Hai)
Bangladesh	#2 (Smiling Sun), #4 (Manoshi), #7 (Projahnmo/MaMoni)
Nepal	#8 (Women's Health Groups in Perinatal Health)
Pakistan	#3 (PAIMAN)
Programs Addressing Safe Motherhood/Birth Preparedness	
India	#12 (Advocacy for Safe Motherhood)
Nepal	#10 (SUMATA), #11 (Nepal Safer Motherhood Program), #13 (Birth Preparedness Package)
Pakistan	#14 (Safe Motherhood Applied Research and Training)
Programs Addressing Diarrhea Prevention (ORS, POU, Water Disinfection, Sanitation)	
India	#15 (SBK), #16 (POUZN Project), #17 (Community-Led Total Sanitation), #18 (Sesame Workshop India)

VI. Index of Case Studies by Good Practice

Good Practice	Case Studies
360-degree approach	#1 (Sure Start), #2 (Smiling Sun), #3 (PAIMAN), #4 (Manoshi), #10 (SUMATA), #11 (Nepal Safer Motherhood Program), #15 (SBK)
Adaptation of materials to local context	#8 (Women's Health Groups in Perinatal Health), #14 (Safe Motherhood Applied Research and Training), #16 (POUZN)
Communication planning cycle	#2 (Smiling Sun), #11 (Nepal Safer Motherhood Program)
Detailed audience segmentation	#1 (Sure Start), #16 (POUZN)
Extensive provider training/support	#2 (Smiling Sun), #6 (Muskaan Ek Abhiyan), #7 (Saving Newborn Lives), #11 (Nepal Safer Motherhood Program), #13 (Birth Preparedness Package), #14 (Safe Motherhood Applied Research and Training), #18 (Sesame Workshop India)
Focus on sustainability	#1 (Sure Start), #3 (PAIMAN), #5 (CLICS), #7 (Saving Newborn Lives), #9 (Kyunki Jeena Isi Ka Naam Hai), #11 (Nepal Safer Motherhood Program), #12 (Advocacy for Safe Motherhood), #13 (Birth Preparedness Package), #15 (SBK), #16 (POUZN), #17 (Community-Led Total Sanitation)
High-quality media programming	#1 (Sure Start), #9 (Kyunki Jeena Isi Ka Naam Hai), #15 (SBK), #18 (Sesame Workshop India)
Participatory processes	#4 (Manoshi), #5 (CLICS), #8 (Women's Health Groups in Perinatal Health), #17 (Community-Led Total Sanitation)
Robust research	#4 (Manoshi), #9 (Kyunki Jeena Isi Ka Naam Hai), #15 (SBK), #18 (Sesame Workshop India)
Strong/innovative partnerships	#1 (Sure Start), #3 (PAIMAN), #5 (CLICS), #6 (Muskaan Ek Abhiyan), #10 (SUMATA), #12 (Advocacy for Safe Motherhood), #15 (SBK), #16 (POUZN)
Strong community–health services linkages	#7 (Saving Newborn Lives), #14 (Safe Motherhood Applied Research and Training)
Strong product/service branding	#2 (Smiling Sun)
Targeting of MNCH influencers	#3 (PAIMAN)
Theory/model as foundation	#10 (SUMATA), #17 (Community-Led Total Sanitation), #18 (Sesame Workshop India)

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