

# **IMPROVING HEALTHY BEHAVIORS PROGRAM IN INDIA**

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**Family Health International (FHI 360)**

**Annual Report:**

**OCTOBER 25, 2010 TO SEPTEMBER 30, 2011**

**Improving Healthy Behaviors Program  
(IHBP)  
ANNUAL WORK PLAN  
VERSION 3**

**OCTOBER 25, 2010 TO SEPTEMBER 30, 2011**



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## Acronyms

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ACSM	Advocacy, Communication, and Social Mobilization
AMP	Award Monitoring Plan
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ASHA	Accredited Social Health Activist
AWP	Annual Work Plan
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BMGF	Bill and Melinda Gates Foundation
BSS	Behavioral Surveillance Survey
CBO	Community-Based Organization
CHC	Community Health Center
CII	Confederation of Indian Industry
CM	Contracts Manager
COP	Chief of Party
CSW	Commercial Sex Worker
DAPCU	District AIDS Prevention and Control Unit
DFID	Department for International Development
DLHS	District Level Household and Facility Survey
DOHFW	Department of Health and Family Welfare
DOTS	Directly Observed Treatment, Short-course
FICCI	Federation of Indian Chambers of Commerce and Industry
FM	Finance Manager
FP/RH	Family Planning/Reproductive Health
GOI	Government of India
GOUP	Government of Uttar Pradesh
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HLFPPT	Hindustan Latex Family Planning Promotion Trust
ICDS	Integrated Child Development Services
ICT	Information Communication Technology
IDU	Injecting Drug User
IEC	Information, Education, and Communication
IFA	Iron Folic Acid
IFPS	Innovations in Family Planning Services
IHBP	Improving Healthy Behaviors Program
IIMC	Indian Institute of Mass Communication
INHP	Integrated Nutrition and Health Program
IPC	Interpersonal Communication
IR	Intermediate Result
IRB	Institutional Review Board
ITAP	Innovations in Technical Assistance Project

JMM	Joint Monitoring Mission
JNU	Jawaharlal Nehru University
JRM	Joint Review Mission
JSK	Janasankhya Sthirta Kosh (Population Stabilization Fund)
JSY	Janani Suraksha Yojana
KAP	Knowledge, Attitudes, and Practices
KM	Knowledge Management
LGBT	Lesbian, Gay, Bisexual, Transgender
M&E	Monitoring and Evaluation
Mamta – HIMC	Mamta Health Institute for Mother and Child
MCH	Maternal and Child Health
MCH STAR	Maternal and Child Health Sustainable Technical Assistance and Research
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
MDR	Multi-Drug Resistant
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MOIB	Ministry of Information and Broadcasting
MOWCD	Ministry of Women and Child Development
MPR	Ministry of Panchayati Raj
MRD	Ministry of Rural Development
MSM	Men Who Have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NFHS	National Family Health Survey
NGO	Nongovernmental Organization
NHCS	National Health Communication Strategy
NHSRC	National Health Systems Resource Centre
NIHFW	National Institute of Health and Family Welfare
NIPCCD	National Institute of Public Cooperation and Child Development
NRHM	National Rural Health Mission
ORS	Oral Rehydration Salts
PAG	Project Advisory Group
PD	Project Director
PHC	Primary Health Center
PLHIV	People Living with HIV
PPP	Public-Private Partnership
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RGI	Office of Registrar General India
RNTCP	Revised National Tuberculosis Control Program
SACS	State AIDS Control Society
SAP	State Action Plan
SBCC	Social and Behavior Change Communication

SIHFW	State Institute of Health and Family Welfare
SOW	Statement of Work
SPAG	State Project Advisory Group
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TB	Tuberculosis
TNA	Training Needs Assessment
TOR	Terms of Reference
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UP	Uttar Pradesh
UPSACS	Uttar Pradesh State AIDS Control Society
USAID	United States Agency for International Development
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WHO	World Health Organization

## I. Background

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### A. Introduction

On October 25, 2010, the United States Agency for International Development (USAID)/India awarded a Task Order to AED to implement a project called “Behavior Change Communication – Improving Healthy Behaviors Program in India” (IHBP) for a base period of 3 years with 2 option years. The overall goal and approach of IHBP is to improve adoption of positive healthy behaviors through institutional and human resource capacity building of national, state, and district-level institutions. The geographic focus at the state level is Uttar Pradesh (UP), where IHBP will cover 10 districts.

The project will provide technical assistance (TA) to develop sustainable national, state, and district institutional capacity to design, deliver, and evaluate strategic evidence-based communication programs that will:

- Increase knowledge and attitudes 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, e.g., women, people living with HIV (PLHIV), and tuberculosis (TB) patients, to demand and access health services

The project will focus on four program areas: HIV/AIDS, family planning/reproductive health (FP/RH), TB, and maternal and child health (MCH).

This narrative incorporates comments received from USAID on March 29, 2011 and May 31, 2011. It provides the background and explanation to the IHBP work plan for the first year of the project from October 25, 2010 to September 30, 2011. It describes activities to be implemented, taking into account the slowdown in implementation from December 2010 to March 2011 due to the AED suspension by USAID, announced in December 2010.

### B. IHBP Intermediate Results

USAID/India’s Health Results Framework aims to improve the health of target populations and to reduce morbidity and mortality in support of India’s efforts to achieve the Millennium Development Goals (MDGs). USAID’s Assistance Objective in India is to strengthen health systems to address health needs of vulnerable populations. IHBP will contribute to achievement of this assistance objective, specifically, to Intermediate Result (IR) 3, Increased Healthy Behaviors, through four key results:

- **Result 1:** Institutions and capacity strengthened to design, deliver, and evaluate strategic communication at national, state, and district levels
- **Result 2:** Accurate and appropriate knowledge/attitudes increased in individuals, families, communities, and providers at district, state, and national levels
- **Result 3:** Community platforms, organizations, and key individuals (influencers) support improved health behaviors

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

### **C. Situation Analysis and Problem Statement**

With a maternal mortality rate of 254 per 100,000 live births (RGI 2004-2006) and infant and under-5 mortality rates of 57 and 74 per 1,000 live births (NFHS-3), respectively, India accounts for 25% or more of maternal and child mortality worldwide. Similarly, with 22% of newborns with low birth weight, 48% of children under age 5 stunted, 43% underweight, and 20% wasted (NFHS-3), India contributes more than 25% of deaths and of the worldwide disease burden among children under 5 (WHO 2006). The situation in UP is much worse than the national average, and the problem in UP is compounded by its large and primarily rural population, widespread poverty, high illiteracy among its women, the inaccessibility of its vulnerable populations, and the limited exposure of its rural women to the media.

The District Level Household and Facility Survey 3 (DLHS-3) of 2007–08 found 23.8% of couples in UP with unmet needs for family planning, but only 9.8% using a modern spacing method, and only 6.9% adopting a spacing method consistently for more than 6 months. Only 22.7% of current users had been told about the side effects of FP methods. Among the non-user couples, only 19.8% reported ever receiving counseling by a service provider.

With a maternal mortality ratio of 517 per 100,000 live births (National Family Health Survey III [NFHS-3]), UP also continues to face the burden of high maternal deaths, most of which are avoidable. Only 26% of women in UP received three antenatal care (ANC) visits, compared to 52% at the national level, and only 8.7% reported consuming a full dose of iron folic acid (IFA) tablets. Institutional deliveries were reported at 22% (DLHS-3, 2007-08) and 44% (Population Council Study, 2010), and only 14% of mothers received a visit from a health care worker within 48 hours of delivery. A survey conducted by the Population Council (2010) cited reasons for women not opting for institutional delivery, such as the perception that delivery is normal and hence institutional care is not needed, the decision of the mother-in-law and/or husband, and lack of preparedness. The same survey established that women contacted by accredited social health activists (ASHAs) during the last delivery were three times more likely to deliver in a health facility. Additionally, having three or more antenatal checkups was positively correlated with institutional delivery, early breastfeeding, post-natal care within 7 days of delivery, full immunization of children between 12 and 23 months, and post-partum contraception for birth spacing.

At 73 per 1,000 live births, the infant mortality rate in UP is the highest among Indian states and much higher than the national average. More than half the deaths of children who die in the first 5 years of life occur in the first month after birth. Full immunization coverage in UP is 23.0%, compared to 43.5% overall in India. Only 7.2% of children under 3 years in UP (versus 23.4% in India) are breastfed within 1 hour of birth. An average of 51% of children age 0–5 months in UP are exclusively breastfed (46% in India). About 85% of children 6–35 months are anemic and 52% are underweight.

According to Government of India (GOI) estimates, 2.3 million Indians were living with HIV in 2007, and those most at risk are female commercial sex workers (CSWs), men who have sex with men (MSM), and injecting drug users (IDUs). Women now comprise 40% of PLHIV. While the National AIDS Control Organization (NACO) has categorized UP as a low-prevalence state, the 30 eastern districts are particularly vulnerable and include several (Allahabad, Deoria, Etawah, Banda, and Mau) classified as high-burden districts (District Categorization for Priority Attention, NACO, 2008).

Increased vulnerability in these districts is attributed to high migration, poverty, and illiteracy, compounded by groups practicing high-risk sex. A 2009 Behavioral Surveillance Survey (BSS) found that, among the general population, HIV awareness is high across all states except UP where it is 79%. Rates of condom use and perception of risk levels among migrants in UP is low. The National AIDS Control Program III (NACP III) 2009 Joint Mid-Term Implementation Review identified the following behavior change communication (BCC) challenges:

- Plans focus on resources and outputs, not outcomes.
- Campaigns lack a focus on reducing discrimination and stigma by health providers.
- The capacity for quality information, education, and communication (IEC)/BCC is weak at State AIDS Control Society (SACS) and District AIDS Prevention and Control Unit (DAPCU) levels.
- Only 2%–3% of the IEC budget goes to monitoring and evaluation (M&E).
- Interpersonal communication (IPC) activities by health workers have rarely been evaluated.

The World Health Organization (WHO) Global TB Control Report 2010 cites India as a country with a high TB burden, high HIV burden, and high multi-drug resistant (MDR)-TB burden. All forms of new TB cases are estimated at 100–299 per 100,000 persons and, of these, the estimated HIV prevalence in new TB cases could be in the range of 5%–19%. There is a 50%–60% lifetime risk among PLHIV of contracting TB.<sup>1,2</sup> The NFHS-3 revealed that the active TB population is close to 425 per 100,000 persons. In UP, prevalence rates are estimated at 426 per 100,000 persons and prevalence is highest in households using solid fuels (coal, charcoal, wood, etc.) for cooking. Misconceptions about TB transmission are high. A 2009 Joint Monitoring Mission (JMM, 2009) on the Revised National Tuberculosis Control Program (RNTCP) identified notable disconnects between interventions envisaged at the national level and what has been happening in the field, e.g., objectives and components laid out in the National Health Communication Strategy (NHCS) are not reflected at the state and district levels and state and district IEC action plans are not based on an analysis of needs, program data, or existing knowledge, attitudes, and practices (KAP) survey data.

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<sup>1</sup> Pathni, A.K. et al. "HIV/TB in India: A public health challenge." *Journal of Indian Medical Association*. 2003 Mar; 101 (3):148-9.

<sup>2</sup> <http://www.searo.who.int/en/Section10/Section2097/Section2129.htm>. Accessed on April 12, 2011.

The same JMM report identified these BCC challenges:

- Stigma continues to isolate patients and impairs effective referral, treatment, and care.
- IEC focuses on materials production and information rather than more persuasive, behavior-centered approaches.
- Patients have poor awareness of their disease or treatment duration.
- Mutual distrust limits civil society engagement.
- State/district managers give IEC low priority due to lack of capacity, poor perception, and inadequate recognition.

The report's major recommendations for IEC/BCC include:

- Engage professionals and/or partners to strengthen and lead advocacy, communication, and social mobilization (ACSM) strategic planning at the national level and support across the RNTCP network, and work closely with National Rural Health Mission's (NRHM) communication stakeholders.
- Concentrate on achieving universal awareness of the right to, and availability of, free TB treatment and care.
- Enhance social mobilization and interpersonal communication.

Recent systematic reviews of health interventions have documented that home and community-based interventions implemented at scale can reduce the burden of maternal, newborn, and child mortality, morbidity, and undernutrition in settings characterized by high disease burdens and weak health systems. However, it is important to identify the key behaviors requiring intervention that must be targeted to achieve this high impact. Socio-cultural and structural barriers, including limited awareness, socio-cultural norms, misconceptions about health behaviors, women's limited autonomy and self-efficacy, and poor access to health care, underlie the low uptake of effective practices. At the same time, more evidence is needed on key influencers who are most likely to inspire behavior change among end-users, as well as factors that influence behavior change in different socio-cultural settings.

### **Role of Communication**

Communication strategies play a powerful role in addressing many of the social and structural barriers to healthy behaviors and in shaping demand for and adoption of healthy preventive practices. However, access to BCC in HIV/AIDS, FP/RH, TB, and MCH is far from universal, particularly among women in UP. For example, the NFHS-3 reports that as many as 40% of women in UP had not heard or seen a single FP message through radio, TV, newspapers, magazines, or wall paintings in the months preceding the interview and that just 20% of women had contact with a frontline health worker in the 3 months preceding the interview.

Reach of health messages and communication materials has been low, especially in UP. The 2010 Population Council survey revealed that only one-fourth of the government facilities had leaflets and counseling aids available and most of these did not address specific family health issues, such as pregnancy danger signs and immunization. Only one-fifth of frontline health workers reported that they had been provided with any materials for distribution or as counseling

aids. In mid-media, mainly *Janani Suraksha Yojana*<sup>3</sup> (JSY), immunization schedules were painted on Primary Health Center/Community Health Center (PHC/CHC) walls, and only 20% of facilities had wall paintings on birth spacing, post-partum care, and exclusive breastfeeding or complementary feeding.

Further, there are several drawbacks to past and current communication initiatives.

- First, few are evidence-based.
- Second, few use integrated communications with multiple channels or attempt to use the potential of information communication technology (ICT) applications for communicating at scale.
- Third, most communication initiatives fail to ensure alignment across behavioral targets, communication channels, and messages.
- Fourth, messages are often imparted in a somewhat technical way and are rarely conveyed in the local dialect; these efforts fail to address such central issues as gender inequities, reproductive rights, and the importance of sharing responsibilities among key influencers within the family.
- Fifth, various factors, including lack of training and adherence to traditional social norms, hinder the ability of health providers to promote appropriate preventive practices.
- Finally, relatively few initiatives have been rigorously evaluated and documented.

### **Barriers and Facilitating Factors**

Formative research conducted by the Population Council has identified key barriers and incentives that shape the demand and adoption of targeted behaviors. These are discussed below.

1. Media analysis shows that only about 48% of rural women in UP aged 15–34 are exposed to any mass media, and the percentage among disadvantaged groups is even lower. For a BCC strategy in rural UP, mid-media, including community radio and IPC, need to be the prime sources of information dissemination. The exponential increase of mobile phones in rural areas could provide an excellent opportunity to use mobile technology for communication.
2. Field observations show that women and community members perceive ASHAs, Anganwadi workers (AWWs), and auxiliary nurse midwives (ANMs) to be credible sources of health information. However, the study also shows that most information provided by ASHAs centers around incentivized practices, such as promoting three ANC visits, institutional delivery, and full immunization. Furthermore, the ANMs, ASHAs, and AWWs each provide information only in their area of activities. As a result, there is no alignment of health messages. In addition, frontline workers lack counseling skills. These findings point to the need for continued education of the frontline workers in both technical areas and BCC counseling.

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<sup>3</sup> Literally translated as “Maternity Protection Scheme,” JSY is a scheme under NRHM that combines conditional cash transfers, cost subsidization, and incentives for pregnant women to undertake ANC, institutional delivery, and post-natal care in a public health facility and for community health workers called ASHAs to facilitate pregnant woman’s access to MCH services.

3. While mothers-in-law are important influencers, research shows that the involvement of husbands is critical to the adoption of healthy behaviors. BCC campaigns focusing on the family must target husbands as well as the women in the family.

### **BCC Structures**

The 2008 UNICEF *Report on Enhanced Capacity of Government Partners for BCC* provided a comprehensive assessment of the capacity needs of the Ministry of Health and Family Welfare (MOHFW), the GOI, and state IEC Bureaus that must be addressed to strengthen implementation of the Reproductive and Child Health II (RCH-II) program. The assessment identified organizational issues within the national and state IEC Bureaus that result in, among other things, the absence of an evidence-based integrated BCC strategy, a low utilization of funds, a focus on mass media and print materials, and the absence of pretesting of materials. The NRHM framework emphasizes the importance of a common approach to IEC for health. However, the IEC Bureaus and the Disease Control Programs do not share a common understanding of BCC. The lack of coordination with other MOHFW health programs—a situation that is evident in UP—misses opportunities to maximize outreach and effective service delivery. The Mid-Term Review Report of RCH-II (GOI, 2008–2009) highlights the following BCC gaps:

- Limited capacity within the system for management of evidence-based BCC
- Inadequate provision of crucial services like ANC, emergency contraception, and safe abortions
- Stand-alone IEC/BCC activities with minimal linkage to service delivery
- Weak counseling at facilities

### **BCC in Uttar Pradesh**

The BCC strategy of the Government of Uttar Pradesh (GOUP) under the NRHM identified similar gaps: weak BCC supervision at the state, district, block, and village levels; weak capacity for planning and implementing BCC programs; weak community-based BCC inputs; uncoordinated and unfocused mass media campaigns; lack of capacity to implement BCC programs at scale; and a need for orienting all health personnel in the state. A review of the 2010–2011 State Action Plan (SAP) of UP reveals that the GOUP is aware of these issues. Fourteen core trigger behaviors have been identified for change and the plan includes a sound communication strategy. It proposes an integrated approach and has identified various useful village and community platforms, such as *Godhbharai* celebrations (a ceremony placing gifts on a pregnant woman's lap), *Saas-Bahu Sammelans* (mother and daughter-in-law meetings), and Village Health and Nutrition Days (VHNDs), that could be used to stimulate the adoption of target behaviors. The SAP not only stops short of underlining the importance of identifying barriers and facilitating factors that affect uptake of target behaviors, but also fails to reflect appreciation of the challenges in implementing the proposed strategy, with negligible allocation of M&E resources for the BCC campaign.

The observations from the recently concluded 4th Common Review Mission for UP have implications for IHBP, especially in using ASHAs for IPC in their mentoring and supportive

supervision, in improving the effectiveness of community platforms like *Saas-Bahu Sammelans* and VHNDs, and in strengthening human resources for BCC in the state TB cell.

The task ahead is clearly laid out. Be it the Joint Review Missions (JRM)s called by the GOI, GOUP's NRHM BCC Strategy for UP (2008), or USAID's BCC Baseline Survey of UP, the need for an evidence-based, multi-pronged, well-planned, and consistent BCC strategy for sustained gains in health interventions is highlighted throughout.

#### **D. IHBP Guiding Principles**

The IHBP project will adhere to USAID/India's funding policy, which views its resources as providing catalytic support, sources of innovation, and models and pilots for more effective and efficient use of the substantial funds that are available from the GOI and other donors. Rather than invest in direct implementation, USAID supports quality TA, cooperation, and partnership, with selected implementation and service delivery assistance to be based on compelling need or political imperatives. Using this approach of providing mainly TA, with only strategic use of limited funding for direct implementation, the project will follow these guiding principles.

##### **1. Focus on Systems Strengthening**

The project will strengthen the existing systems responsible for all aspects of BCC programming, going far beyond BCC training. It will include strengthening organizational and management structures and systems, advocating for additional human resources, improving budgeting and disbursement of funds, and reinforcing coordination within relevant government departments and nongovernmental organizations (NGOs), as well as the private commercial sector.

##### **2. Coordination and Integration**

BCC coordination mechanisms will be strengthened within relevant programs of the MOHFW and inter-ministerially among the MOHFW, the Ministry of Women and Child Development (MOWCD), and other relevant agencies, such as the Ministry of Rural Development (MRD), the Ministry of Panchayati Raj (MPR), and the Ministry of Information and Broadcasting (MOIB), at national and state levels and among key units at the district, block, and village levels.

Coordination between government and NGOs, including the various health alliances working in UP, will be enhanced. The project will establish a Project Advisory Group (PAG) with national- and state-level members drawn from different programs under the NRHM, from the MOWCD and stakeholder agencies. The Advisory Group will recommend mechanisms for improving coordination between the different vertical programs of the government and will also periodically review the progress of the IHBP and provide advice on this issue. In addition, the project will make use of existing program review platforms within the system, like the JRM)s called by the GOI, to advocate for enhanced coordination between programs and across government departments and to increase accountability in this regard. The first year will focus on strengthening coordination among various divisions, departments, and agencies in the MOHFW that are implementing the RCH and RNTCP programs under NRHM, and the NACP program, with a secondary focus on the MOWCD; succeeding years will move toward more inter-ministerial coordination.

### **3. Evidence-Based BCC**

Although India's public health system has shifted toward evidence-based and outcome-oriented programming, BCC programs have not. Key recent reviews, such as UNICEF's BCC capacity assessment, the Population Council's recent research in UP, and UP's own BCC strategy document, all identify the need for BCC programs to focus on key behaviors and to address social and cultural barriers to change and engage influencers. The project will advocate for and implement an evidence-based BCC approach at all levels, with funds for implementation of BCC activities provided by the government budget.

### **4. Advocacy**

Advocacy with government decision makers at all levels will be a key component since capacity building and BCC activities under all IRs need to be owned by the government agencies that will provide resources for implementation. Advocacy strategies will also be critical to building an enabling environment for BCC.

### **5. Accountability and Recognition**

The project will help create simple but robust M&E systems at all levels to provide feedback to health workers on their BCC performance and institute a system that salutes ASHAs, ANMs, AWWs, *sarpanchs*,<sup>4</sup> community influencers, and health providers who are proven to be "outstanding communicators for behavior change." The project will also commend mothers and fathers, TB patients, and other community members who are practicing positive health behaviors, so that these behaviors become community norms.

### **6. Leveraging**

The project has identified a number of innovative public-private partnership (PPP) and leveraging ideas that have been discussed with business sector leaders and organizations like the Federation of Indian Chambers of Commerce and Industry (FICCI) and the Confederation of Indian Industry (CII). The project's approach to leveraging will endeavor to forge partnerships within a "win-win" setting with commercial companies, civil society organizations, government institutions, international and national donors, and the media. The project will work with the commercial sector within the parameters of two general approaches: working with corporate social responsibility programs that are interested in investing in the target districts in UP or in improving BCC capacity at the national or state levels, and developing sustainable "win-win" situations wherein a company can expand the commercial availability of its relevant health products or services that are a part of its core business, in collaboration with the project and USAID.

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<sup>4</sup> A *sarpanch* is a democratically elected head of a village-level statutory institution of local self-government called the *gram panchayat* (village government) in India. The *sarpanch* is the focal point of contact between government officers and the village community.

## E. Implementation Strategy

Our implementation strategy for institution strengthening will be to provide TA through a mentoring, learning-by-doing approach through selected nodal organizations, seconding BCC specialists to work closely with government at the national and state levels, and assigning project staff at the district level to provide day-to-day TA to government partners on BCC. The project views *nodal institutions* as public institutions, e.g., the National Institute of Health and Family Welfare (NIHFW), the State Institute of Health and Family Welfare (SIHFW), and the National Institute of Public Cooperation and Child Development (NIPCCD); academic institutions, e.g., the Indian Institute of Mass Communication (IIMC), and Jawaharlal Nehru University (JNU); or private organizations, e.g., nongovernmental organizations (NGOs) and for-profit agencies, that will provide training and technical support services to GOI and GOUP programs. The project will develop the capacity of these selected nodal institutions through a mentoring approach, so that by the end of the project life, they will be able to fully take on the technical support role that the project has been providing. Final nodal institution selection will be made in consultation with USAID, the GOI, and the GOUP.

Based on agreements to be developed with the government agencies, the project will also deploy one key BCC specialist as a consultant or project resource in GOI and GOUP counterpart offices in each location. These focal persons, if approved by government, will provide day-to-day liaison between the project and department officials. The project plans to place four full-time equivalents at both the national and state offices from the second to third years. One district-level consultant per district, jointly selected with relevant district government agency personnel, with each serving 2 years, will be phased in according to the district rollout. Specific Statements of Work (SOWs), to be finalized with government counterparts, for these seconded consultants will likely include such tasks as

- Developing and mentoring staff planning skills
- Increasing training skills of master trainers
- Developing evidence-based materials
- Strengthening organizational structures, budgeting, and monitoring

Transition mechanisms for all specialists/consultants will be put in place during discussions with government officials during project-led planning sessions and TA. Following the 2-year consultancy, the project will work to have government systems in place to support these positions, initially either as consultants transitioning to permanent hires or as permanent hires with specific job descriptions related to promoting social and behavior change communication (SBCC). Considering the importance of the district as the “key connection” between planning and implementation, the project will place three to four project-employed staff in each of the 10 priority districts, to mentor government BCC partners, e.g., the Chief Medical Officer (Family Welfare), District Health Information and Education Officers, and District TB Officer, and to facilitate activities in institution strengthening, BCC, community mobilization, advocacy, and M&E.

Ten districts in UP will be the focus of activities at the state level. Of the 10 districts, an initial set of 5 from the USAID high-focus districts in the state has been recommended for planning: Budaun, Banda, Sitapur, Chitakroot, and Kaushambi. The final selection of the aforementioned districts will be confirmed with government and USAID based on their current priorities. Similarly, the remaining five districts will be identified in collaboration with USAID and the GOUP. The strategy for district implementation will be to launch activities in six districts in the latter part of Year 1 and move on to launch in the remaining four districts in Year 2. The project will propose district selection criteria that will identify vulnerable districts based on socio-demographic data, relevant behavioral and service delivery indicators regarding the four program elements, management indicators, and the existence of USAID- or other donor-funded activities. The proposed strategy will target achievement of a core set of health behavior indicators (minimum package) in all 10 districts. Additional indicators for specific districts will be included based on the specific needs and gaps for the district in any of the four program elements.

## **II. Work Plan Description: October 2010 to September 2011**

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### **A. Result 1: Institutions/Capacity Strengthened**

From February through September 2011, the project will lay the foundation for strengthened government collaboration, conduct assessments to develop institution strengthening plans, and identify and select nodal institutions. All activities will be undertaken in partnership with government institutions following a mentoring, learning-by-doing approach.

#### **1. Lay the Groundwork for Strengthened Government Collaboration in Delhi and Uttar Pradesh**

During the first year, the project will lay the groundwork for strengthened government commitment and collaboration within the topmost echelons of MOHFW involved in HIV/AIDS, FP/RH, TB, and MCH programs. These include NACO for NACP; MOHFW's departments implementing the RNTCP, RCH, and MCH programs and their technical agencies like the National Health Systems Resource Centre (NHSRC) and the National Institute of Health and Family Welfare (NIHFW) in Delhi; and their counterpart institutions in UP. Initial contacts with the MOWCD may also occur. Efforts targeting other relevant agencies, like the MPR, the MRD, and the MOIB, at the national and state levels will be initiated in Year 2. During these meetings, the project will encourage the various ministries at the national and state levels and their technical agencies to appoint a nodal person to provide inputs on technical documents, identify common areas for work, and coordinate with IHBP for SBCC-related TA. During the fourth quarter of Year 1, the project will establish a Project Advisory Group (PAG) at the national level, consisting of representatives from stakeholder ministries, government agencies, USAID/India, USAID implementing partners, and other stakeholders. The PAG will be an advisory cum advocacy body, which will primarily provide strategic guidance to the project in technical areas related to BCC, provide access to key documents relevant to the project, and function as a champion for the project and its objectives. A similar body with a matching purpose called the State Project Advisory Group (SPAG) will be established at the state level. The PAG and the SPAG will not be involved in approving plans, activities, and budgets. The project team will draft written Terms of Reference (TOR) for the advisory groups and will share it with USAID/India before finalizing their contents and constituents. In the fourth quarter of the first year, the project will establish the PAG and SPAG at the national and state levels, respectively.

For more detailed planning and review on different functional areas, working groups will be formed at national and state levels, as required, comprising floating members from different programs and departments. These working groups will be involved in planning and implementation of activities with project staff on a daily basis. Orientations on the project and on BCC will be held for senior officials in the IEC units and the HIV/AIDS, FP/RH, TB, and MCH program units. Orientations on the project and on BCC will also be held for officials and master trainers of current government training institutes: NIHFW, the National Institute of Public Cooperation and Child Development (NIPCCD), and NHSRC.

The results of these activities will be agreement documents on the project signed with relevant government agencies at the national and state levels, with approvals to proceed with specific activities like organizational needs assessments, baseline studies, and performance needs assessments of Village Health and Sanitation Committees (VHSCs) on BCC.

During Year 1, the project will aim to actively participate in the planning of NRHM-II, NACP-IV, and RNTCP, with a focus at strengthening their BCC components. Considering Year 2 plans to collaborate more intensively with MOWCD, the project will also participate in the planning of Integrated Child Development Services-IV (ICDS-IV).

## **2. Conduct Assessments as Bases for Developing Institution-Strengthening Plans at National, State, and District Levels**

During Year 1, concurrent to the review of the BCC situation (refer to Section II.B.1 below), an organizational needs assessment of BCC in the MOHFW and relevant divisions (NACO, RNTCP, and RCH) at the national and state levels will be conducted, with a similar exercise for MOWCD to be initiated in Year 2. This needs assessment, updating previous reviews, will cover organizational and management structures, systems, and processes that have implications for effective BCC planning, implementation, and evaluation for HIV/AIDS, FP/RH, TB, and MCH at the national, state, and district levels. The needs assessment exercise will document the current organizational structure of the MOHFW and relevant divisions as it relates to IEC/BCC. Areas for review will include, among others, management structures and processes in terms of staffing, responsibilities, activities, and funds and information flows at national, state, and district levels. It will also cover human resource policies and practices, e.g., job descriptions versus actual assignments of BCC/IEC unit staff, including supervisors, actual staff, and supervisor qualifications; recruitment policies and practices; performance appraisal systems; staff remuneration and promotion policies; and any other practices that are relevant to effective functioning of the BCC/IEC unit at the national, state, and district levels. The exercise will also look broadly at the current Management Information System (MIS) and M&E and how it affects the various other aspects of this organizational needs assessment. Government staff's BCC knowledge, attitudes, and skills regarding the process of BCC will be assessed to help define capacity building interventions essential to strengthen BCC at various levels.

A follow-on activity will be an in-depth assessment of the current MIS and M&E systems to provide information for developing BCC indicators and tools for inclusion in the health programs supporting the four program elements. The project will establish a Technical Advisory Group for M&E, which will be consulted for input on organizational assessment vis-à-vis the government M&E system, for building consensus on areas for improvement in the government M&E system vis-à-vis BCC, and for advocating for indicators for BCC strategy and tools for monitoring and evaluating BCC in NRHM, ICDS, RNTCP, and NACP.

A performance needs assessment for strengthening the BCC capacity during the VHNDs, as well as a survey verifying the BCC competencies and processes of various health providers, will be initiated (the latter will be part of the baseline study). The needs assessment will take into

account Training Needs Assessments (TNAs) undertaken by other projects, whether funded by USAID, other donors, or government.

Completion of these assessments is projected for Year 2, at which time dissemination of results will be undertaken and advocacy efforts aimed at acceptance of recommendations will be pursued. Year 2 will be devoted to operationalizing organizational needs assessment recommendations, revising training programs and modules for various categories of BCC workers, and developing BCC indicators and baselines for existing M&E systems.

### **3. Identify and Select Nodal Institutions at the National and State Levels**

Starting in the fourth quarter of Year 1, a scoping study will be undertaken to identify nodal institutions at the national and UP levels based on criteria to be agreed upon with USAID and government. IHBP envisions these institutions to be NGOs or other private sector groups, although public sector institutions may be considered as well. The scoping study results will be discussed with government counterparts and USAID and will be used as basis for selecting the nodal institution(s) at national and state levels. The actual signing of agreements with the nodal agencies selected will be done in Year 2.

### **4. Initiate Baseline Quantitative and Qualitative Study of Health Providers and Frontline Workers**

The IHBP team will undertake a review of quantitative and qualitative studies done in UP in the last 12 months, the questions asked, the tools used, and profiles of target groups and the districts in which the studies were conducted to reduce duplication of data collected. The project will also undertake discussions with other USAID projects to gather similar information on any ongoing research study. As part of M&E activities and based on the review, the project will develop SOWs for the baseline quantitative and qualitative studies and advertise the request for proposal to identify research agencies to conduct them. The project will also draft the study design and tools to share with the Institutional Review Board (IRB) committees for their approval. During the quantitative and qualitative studies, data pertaining to the performance of institutions, providers, and health education personnel will be collected. Two categories of information will be collected: information on BCC processes in practice and KAP on the four program elements.

### **5. Orient District-Level Stakeholders on the Project and on BCC**

Once the districts are selected, the project will initiate work in six districts. In the fourth quarter of Year 1, plans for meetings to introduce district-level stakeholders, including the District Magistrate, to the project will be made.

### **6. Participate in Planning of NRHM-II, NACP-IV, ICDS- IV, and RNTCP**

Across the project year, the IHBP team will participate in the planning process for NRHM-II, NACP-IV, ICDS-IV, and RNTCP to accelerate the institution strengthening and BCC component of the aforementioned programs.

**B. Result 2: Accurate and Appropriate Knowledge/Attitudes Increased among Individuals, Families, Communities, and Providers at District, State, and National Levels**

For the remaining part of Year 1, the project will gather evidence for more effective BCC planning and development of materials and messages. The grants program will be planned and promoted for operationalization in Year 2 (see information below for purpose of grants and implementation modalities).

**1. Conduct Reviews, Gather Secondary Data, and Implement Research as the Basis for Strategic Planning at National and State Levels**

Evidence will be gathered to form the basis for planning. An assessment of the current BCC situation, including existing strategies (like the UP NRHM BCC Strategy), implementation, and M&E approaches, will be undertaken to determine gaps and gather information for strategy revisions, where necessary. A secondary review of existing quantitative and qualitative research findings on HIV/AIDS, FP/RH, TB, and MCH will consolidate existing findings about current attitudes, beliefs, and practices of various target groups. A desk review of best or promising practices on BCC in health in India and South Asia will be undertaken.

The project acknowledges that there are important ongoing initiatives in UP to strengthen mass media, mid-media, and IPC for MCH, FP, and HIV/AIDS. USAID partners, including the Maternal and Child Health Integrated Program (MCHIP), the Vistaar Project, the IFPS Technical Assistance Project (ITAP), the Technical Support Unit of the Uttar Pradesh State AIDS Control Society (UPSACS), the Maternal and Child Health Sustainable Technical Assistance and Research (MCH STAR) Project, the Bill and Melinda Gates Foundation (BMGF)-funded Sure Start and Manthan Projects, and the UNICEF-led technical assistance in the Comprehensive Child Survival Program, are actively supporting implementation of NRHM and NACP-III in UP.

At the national level, there are several development partners, including the Department for International Development (DFID), USAID partners, BMGF partners (e.g., IntraHealth, CARE, and PATH), United Nations agencies (especially UNICEF, the United Nations Development Programme [UNDP], and the United Nations Population Fund [UNFPA]), international NGOs (e.g., International HIV/AIDS Alliance), and national NGOs (e.g., the Hindustan Latex Family Planning Promotion Trust [HLFPPT] and the Mamta Health Institute for Mother and Child [Mamta - HIMC]), that are actively participating in strengthening IEC/BCC activities under the NRHM and NACP.

Based on the gaps identified from the assessments and reviews, quantitative and qualitative research studies regarding HIV/AIDS, FP/RH, TB, and MCH practices will be implemented to generate updated information (where needed) on barriers to desired behaviors and will identify opportunities where BCC strategies and activities can be more effective. A desk review and observations of existing communication platforms (e.g., VHNDs) will elicit information useful for developing guidelines for more effective implementation by frontline workers (assuming gaps are located in this area). The review of existing platforms will take into account extensive work done by other projects on community platforms (e.g., Vistaar on VHNDs). All of these activities will be done in partnership with government and the selected nodal institutions. Reviews of community platforms within the MOWCD network (e.g., ICDS sector and block meetings) will be done in Year 2.

The results of these evidence-gathering activities will be finalized in Year 2. Based on these results, agreements with MOHFW and the Department of Health and Family Welfare (DOHFW) to revise existing BCC guidelines for community communication platforms (if indicated); define new priorities and needs for communication products and activities; and update BCC strategies, plans, materials, and messages will be undertaken in Year 2.

## **2. Review of Best Practices in Behavior Change Communication**

The project will undertake a review of promising, good, and best practices from BCC interventions at national and South Asia levels. The project will use globally accepted standards for defining best practices and good practices in reviewing BCC interventions and lessons learned from them. The best practices report will inform government stakeholders at the national, state, and district levels on practices that can be replicated and scaled-up in UP.

## **3. Develop Grant Guidelines and Promote Grants Program**

Guidelines for the grants program will be drafted during the fourth quarter of Year 1. The grants program will be promoted for implementation in Year 2. NGOs will bid on a defined SOW. A portion of the grants will be set aside for testing project innovations each year. Two types of grants are envisaged: *Community Mobilization Grants* and *Small Grants to Combat Stigma and Discrimination and Improve Alliances*. The guidelines will include a monitoring and reporting system for grants awarded.

### *Community Mobilization Grants*

IHBP proposes to award 30 grants distributed among the 10 districts over the next 2 years (Years 2 and 3) that are competitively bid to local NGOs that are financially sound and have proven track records. The grants will focus on using project-/government-developed campaign strategies and materials. Implementation at the village level will include participating in village-level planning and monitoring; supporting existing platforms, such as farmers' groups and health days; and additional IPC activities, such as conducting demonstrations on market days, establishing grandmothers' and fathers' groups on various health topics, and establishing a team of village leaders to generate word-of-mouth campaigns. These grants will be shared across Results 2 and 3.

### *Small Grants to Combat Stigma and Discrimination and Improve Alliances*

Under Result 4, IHBP will award four grants for 2 years each that are competitively bid to local NGOs that are financially sound and have proven track records. The grants will focus on building alliances among and empowering marginalized groups, such as women, PLHIV, TB patients, youth, Scheduled Castes/Scheduled Tribes, and Other Backward Castes.

#### **4. Initiate Community and Household-Level Baseline KAP Surveys**

Baseline KAP surveys will be initiated with relevant stakeholders at the community level (e.g., community leaders, elected representatives, VHSC members, community-based organizations [CBOs]), and households. Household respondents will include mothers, fathers/men, and family members. Household baseline data will be collected in up to six intervention districts and a control study group. Data at the household level will include measures of practices associated with the core set of health behavior indicators or the minimum package of indicators for all relevant content areas to be adopted by the project, as well as measures of exposure to project-supported activities through the different channels to be used. Relevant socio-demographic variables will be included. Qualitative studies will be undertaken to supplement information collected in quantitative studies.

#### **C. Result 3: Community Platforms, Organizations, and Key Individuals (Influencers<sup>5</sup>) Support Improved Health Behaviors**

The remaining part of Year 1 will be used to gather evidence through assessments and formative research studies, to guide community mobilization and alliance-building plans and to refine or develop communication approaches, materials, and messages for greater efficacy. From the group of influencers, champions or spokespersons<sup>6</sup> for health will be identified to be able to speak publicly about health issues and promote healthy behaviors. Media mapping will be undertaken at the national and state level in Year 1 and at the district level in Year 2.

#### **1. Initiate Analysis of Key Influencers and Alliances for Health at National, State, and District Levels**

During the fourth quarter of Year 1, the project will initiate research to identify key influencers from various sectors, including media, who can shape opinion and become champions or spokespersons for improved behaviors on HIV/AIDS, FP/RH, TB, and MCH. A situation analysis of existing alliances for various health issues will be undertaken to identify those which IHBP can tap and sustainably build on. There are some interesting private sector initiatives, like the *Bhavishya* Alliance, ICICI Foundation for Inclusive Growth, Britannia Foundation, etc., which seek to improve healthy behaviors. The mapping will include alliances and networks

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<sup>5</sup> Influencers are defined as persons who can influence decision making by members of the project's target groups. These influencers can include elected representatives, health workers, government officials, community leaders, religious leaders, activists, celebrities, role models, family members, media personalities, and others.

<sup>6</sup> Champions and/or spokespersons for healthy behaviors will be selected among the above categories of influencers. They will be identified and trained to be able to authoritatively speak in public about specific health issues and to promote healthy behaviors among the specific target group segments they have strong influence on.

established by NGOs and private organizations. This analysis will take into account similar assessments and reviews that have been conducted under different projects. These reviews will be used to develop and finalize community mobilization and alliance-building strategies and plans that will include training of champions and spokespersons (selected from the influencers mentioned above) in Year 2. These evidence-gathering activities will be done in close collaboration with government and the selected nodal institutions. The project envisions not only strengthening existing alliances but also forging new and innovative partnerships, including some with private sector stakeholders. An analysis of district-level alliances and networks will be undertaken in Year 2.

It is anticipated that partnerships with champions, alliances, and networks will facilitate the project to create pressure groups and policy and program advocacy opportunities for a more enabling environment for adoption of healthy behaviors and practices by individuals, families, and communities.

## **2. Review Advocacy and Community Mobilization Materials and Modules at National and State Levels**

Existing materials used for advocacy (policy briefs, media briefs, position papers, fact sheets, etc.) and community mobilization (community mobilization guidelines, published declarations, campaign materials, etc.) in HIV/AIDS, FP/RH, TB, and MCH will be reviewed to provide information on use of existing materials, need for revision of existing materials, or development of revised or new ones. Actual development or revision of materials, if necessary, will be done in Year 2, followed by training activities.

## **3. Conduct Media Mapping**

A media mapping exercise will be conducted at the national and state levels to identify potential media allies who can be tapped for various health advocacies. Based on the media map, areas for advocacy to media and capacity building of media organizations and personalities as advocates or champions for specific health issues will be identified. A media advocacy plan will be developed and implemented in Year 2.

#### D. **Result 4: Vulnerable Communities Empowered to Seek Health Services and Products**

The project is exploring the need to work with the following vulnerable segments:

PLHIV: <ul style="list-style-type: none"><li>• Men and women on antiretroviral therapy (ART)</li><li>• Migrant males and their wives</li><li>• MSM and lesbian, gay, bisexual, and transgender (LGBT) people*</li><li>• IDUs*</li><li>• Pregnant HIV-positive women</li><li>• HIV-positive lactating mothers</li><li>• Female sex workers*</li></ul>
Children affected by AIDS (including orphans and vulnerable children)
Men and women suffering from TB
Low caste members
Low-income groups

*\* These are Targeted Interventions under NACP-III and would require capacity building of NACO- approved NGOs.*

Year 1 will focus on gathering evidence to develop materials and messages and identifying some individuals from vulnerable groups to become spokespersons. Training of these spokespersons and implementation of pilot interventions will be done in Year 2.

##### **1. Initiate Baseline Quantitative and Qualitative Studies on Stigma and Discrimination among Health Workers; Lady Supervisors; Health Education Officers at District and Block Levels; Panchayati Raj Institution (PRI) Members; Directly Observed Treatment, Short-Course (DOTS) Providers; HIV Workers; TB Patients; PLHIV; and Men, Women, and Community Influencers**

These studies will be undertaken as part of the baseline quantitative and qualitative studies under Results 1 and 2. If necessary, separate studies will be conducted for key relevant target groups, not covered under IR 1 and IR 2. These studies will probe attitudes, beliefs, and practices of health providers, frontline workers, community influencers and members, women, PLHIV, and people with TB regarding stigma and discrimination. The role of caste as an underlying factor in stigma and discrimination will also be explored. These studies are expected for completion in Year 2. The results will be used to identify effective strategies, activities, and messages for implementation and to identify and train an initial group of PLHIV, current and former/cured TB patients, and women willing to provide testimonials and become advocates or champions to overcome stigma and discriminatory attitudes at the community level from Year 2 onwards. The project will also consider training groups (women, HIV activists, lawyers) to become advocates in the second year.

## **E. Develop and Implement an Award Monitoring Plan and Knowledge Management System**

Year 1 will operationalize the Award Monitoring Plan (AMP) and Knowledge Management (KM) systems.

### **1. Finalize the AMP and Set up System for M&E**

The project's AMP will be finalized with USAID approval and a system will be set in place for its implementation. Monitoring and reporting systems for sub-grants will also be established.

### **2. Develop a KM Strategy**

The project's KM strategy will be developed and finalized. IHBP's KM strategy will lead to improved sharing of project-relevant information; utilization of knowledge across national, state, and district levels by the project team; and dissemination of project experiences and lessons learned to external stakeholders for improvements in future programs on BCC. It will also contribute to strengthening of institutional capacities (partners, government bodies, community workers, etc.) in BCC-related information management, like creating BCC hubs/gateways.

The KM system will also be the channel to gather and disseminate human interest stories, anecdotal evidence, testimonials, statements from champions, and other interesting information on the process and progress of the project. This will add to the body of evidence regarding institution strengthening and change in the environment for healthy behaviors.

### **3. Design and Launch of the Project Website**

Development of the project website will be initiated in Year 1. The project's interactive website will be launched in the early part of Year 2. A monthly newsletter will be disseminated starting in July 2011; it will be incorporated in the website once operational.

## **F. Leveraging and Public-Private Partnerships**

In the proposal for IHBP, AED described innovative and realistic approaches to identifying resources to promote project objectives. The leveraging plan provided details of the project's illustrative leveraging strategy to engage the private sector in co-investments to support health in India. This strategy has the potential to generate significant cash and in-kind resources from multiple stakeholder alliances to achieve solutions not possible by only one actor. For example, cash investments by private sector partners made to cultivate a market for health products can replace the resources required if USAID was to develop a distribution channel and deliver products directly to the public on its own. The proposal identified a variety of sources that will contribute to the leveraging of more than \$66 million in potential resources, which is clearly above the 1:1 USAID/India requirement.

This plan demonstrates IHBP's confidence in meeting the leveraging goals for this project. Given that the majority of leveraging shown in the illustrative plan comes from private sector resources invested in establishing a business model that also achieves project goals, two-thirds of the potential leveraging amount comes in the form of cash. This is not to say that it can be

expected that this potential cash amount represents private sector cash donations to AED or USAID to manage on its own, but rather as part of an alliance that relies on a co-investment strategy for shared risk and success. The leveraged funds in our proposal are of four main types:

- Cash provided to AED or to directly reimburse a specific project cost
- Cash spent by commercial partners for activities created and motivated by the project
- Funds spent by collaborating groups, such as FICCI or the Global Business Council for joint activities on the project
- In-kind contributions, such as health products, venues for project activities, and media time

Year 1 will be devoted to developing relationships with the private sector for leveraging activities, gathering data needed to persuade the private sector to buy in to PPPs, and developing a more specific leveraging strategy for implementation in Year 2.

### **1. Hold Meetings with Private Sector Groups to Orient Them regarding the Project and to Discuss Collaboration in Delhi or Mumbai (if necessary) and UP**

The project will follow up on initial commitments acquired from business sector groups (FICCI, etc.) and identify other groups for leveraging and PPPs. If the need exists, meetings can also be held in Mumbai, where company headquarters are located.

### **2. Gather Data to Support PPP and Leveraging Promotion in Delhi and UP**

During the last quarter of Year 1, the project will gather data (number of people to be reached, investment levels, number of trainings and media activities planned, and demand for a particular health product in a specific area) that will be used to generate commitments from the private sector for PPPs and leveraging. Examples of private sector companies targeted for leveraging include:

- Telecommunication companies for free air time and technical support in sending periodic health messages to mobile phone subscribers
- Advertising agencies that will accept interns from government agencies or nodal institutions to enhance specific BCC skills
- Pharmaceutical companies that will benefit from the project's marketing support to expand the sale of low-cost IFA tablets or oral rehydration salts (ORS)
- Soap manufacturers that will benefit from promotion of hand washing, etc.

Leveraging will target private sector companies that will benefit from BCC activities without necessarily contributing to BCC per se. Companies in UP will also be targeted for leveraging.

### **3. Develop Private Sector Leveraging Strategy for the Project**

Results of the meetings and data gathered as per #2 above will be used to draft a leveraging strategy that will be operationalized in Year 2.

Appendix 1 contains the illustrative list of leveraging activities and potential contributions to our leveraging requirements that was presented in our proposal.

### **III. Award Monitoring Plan**

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The revised draft AMP that is submitted with this revised draft work plan describes how monitoring will be done to ensure that activities are implemented according to plan and result in desired outputs and outcomes.

### **IV. Short-Term Technical Assistance**

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Allocated across the work plan results are international travel costs that include the headquarters technical and managerial support and international short-term TA (STTA). During proposal negotiations, USAID encouraged AED to increase both international and local consultants as reflected in the approved budget and narrative. This wise guidance confirms AED's assessment that international STTA can strategically increase staff's capacity by providing international perspectives, move workloads ahead quicker by taking on discrete assignments, and engage the government on targeted issues related to the technical agenda. AED carefully selects both staff and consultants to provide TA to the project, trying to identify staff with considerable work experience in India. The information provided below is per the proposal's budget notes on page 11 and additional explanations are provided on the role these professionals will play in the project.

#### **A. U.S.-Based Consultants**

1. Pam McCarthy – School Program Design and Formative Research Consultant. This consultant will develop new skills in project staff to use projective techniques in formative research and later on will also develop an activity-based school program that empowers primary school children to spread health messages focused on behavior change to their families and community. This work will build on her experiences in Ethiopia, Gaza/West Bank, Nepal, and Pakistan.
2. AED will identify key consultants with technical and SBCC skills to assist in designing and carrying out technical SBCC activities, such as the review of international best practices of BCC.
3. AED will identify key consultants with organizational development experience to provide technical expertise in organizational development.
4. AED will identify an experienced private sector/leveraging professional with previous India experience to guide the leveraging activities, local consultants, and staff in these efforts.

**B. Table: International Travel of AED Headquarters-Based Staff**

<b>Position</b>	<b>Location</b>	<b>Assignment</b>	<b>Number of trips (days) Year I</b>	<b>Total level of effort for STTA Year I</b>
Project Director (PD). Visits by the PD provide strategic oversight, technical inputs, and quality control/corporate oversight on all aspects of the project. They are more intensive during the first year, but are always conducted at least biannually to support the Chief of Party (COP).	DC to Delhi	Office set-up, hiring, work planning, TA	3 (45)	
Project Officer	DC to Delhi	Office set-up, hiring	1 (30)	Trip completed
Finance Manager (FM). The FM is required to train staff in all accounting and reporting requirements. The second trip will be conducted after the AED acquisition is complete to realign systems as needed. It will probably be moved to Year 2.	DC to Delhi	Set up finance systems	2 (30)	
Contracts Manager (CM). The CM will train staff on all procurement matters to ensure fully compliant processing of all procurements and consultant agreements. Visits are routinely provided when projects start up and after internal audits if compliance issues are identified. The Project Officer and FM have completed the basic training, but follow-up may be required by the CM.	DC to Delhi	Set up contract systems and training	1 (20)	

Position	Location	Assignment	Number of trips (days) Year I	Total level of effort for STTA Year I
<p><b>STTA Experts.</b> Senior staff, most with more than 25 years of experience, are proposed for AED STTA. These STTA experts are essential as they provide global knowledge and experience to help frame project activities. While local expertise is extensive in technical areas, BCC skills and experience are more limited in India. The use of international experts will support capacity building in BCC.</p> <p>In addition, government counterparts often are more receptive when expatriate senior professionals, accompanied by project staff and local consultants, present new approaches or engage in potentially difficult dialogues. In addition to providing capacity building for project staff, international STTA experts also assist the COP, who cannot always provide the intensive strategic directions needed for a specific initiative. Often these STTA experts become mentors to project staff and can provide online support in a timely and cost-effective manner.</p> <p>Additional information on specific STTA experts is in the following rows.</p>				
Jill Randell	DC to Delhi	Technical BCC Support (MCH, Nutrition)	1 (15)	20
Neil McKee	DC to Delhi	Technical BCC Support (HIV, Youth)	1 (15)	18
Rose Roman	DC to Delhi	Technical BCC Support (HIV/TB)	1 (15)	25
Renuka Bery	DC to Delhi	KM and Advocacy	1 (15)	50
TBD. Berengere DeNegri is currently proposed to conduct staff SBCC training and develop training skills. She is currently a member of the AED C-Change staff and is one of AED's most effective trainers in SBCC.	DC to Delhi	Technical BCC Support (FP/RH)	1 (15)	50
TBD. This person would be used only to introduce new methodologies or support a specific technical area where his/her global experience can design the research and instrument questions and also expedite the process.	DC to Delhi	Formative Researcher	1 (15)	30

<b>Position</b>	<b>Location</b>	<b>Assignment</b>	<b>Number of trips (days) Year I</b>	<b>Total level of effort for STTA Year I</b>
<p>Orlando Hernandez. He will provide targeted oversight and technical direction to project baselines/endlines. This important function will ensure the best product for USAID and will also enhance the capacity of project staff. His state-of-the-art knowledge of M&amp;E related to BCC will also be strategically applied to other project issues. For example, he provided the guidance to use principal component analysis for district section. He also has considerable experience in project-level monitoring and will help guide that activity as well.</p>	DC to Delhi	M&E	3 (45)	72

**C. Table: International Travel of U.S.-Based Consultants**

<b>Name</b>	<b>Location</b>	<b>Assignment</b>	<b>Number of trips (days) Year I</b>	<b>Total level of effort for STTA Year I</b>
Pam McCarthy. Given the delays, this will roll over to Year 2. Her unique approach to formative research and superlative training skills have propelled campaigns in other projects to innovations based on state-of-the-art formative research. She is very effective in training project staff to implement these protocols.	Minneapolis to Delhi	Formative Research	1 (15)	30
TBD. This will probably roll over to Year 2.	DC to Delhi	Technical, BCC	1 (15)	50
TBD. Given the delays, this will roll over to Year 2. AED is implementing the C-Change project, which has a large focus on institution strengthening. We can tap that project's consultants, among others, when needed, to provide strategic guidance to the government, project staff, and consultants.	DC to Delhi	Organizational/ Institution Strengthening	2 (30)	42
TBD. This consultant replaces the previously proposed AED staff person. The huge leveraging responsibility requires oversight, innovation, and global expertise to guide the project staff person that will manage the day-to-day activities. The COP is not an expert in PPP. One of these trips will roll over to Year 2. This support will be ongoing.	DC to Delhi	Leveraging/PPPs	2 (30)	47

## Appendix 1

### Illustrative List of Potential Leveraging Sources and Proposed Project Investments to Support Leveraging

Description of Leverage Amount	Leverage Partner Investment
Venue, transportation of participants, materials distribution, local organization for health education sessions on HIV/AIDS, FP/RH, TB, and MCH; 145 company sessions (per year 5+20+40+40+40) 145 x \$2,500 =	<b>\$362,500</b>
Free air time and technical support for the periodic sending of health messages to cell subscribers. \$30,000/yr x 4 years. India has 584 million mobile phone subscribers services by such companies as Airtel, Reliance Infocomm, Vodafone, Idea Cellular, and BSNL/MNTL.	<b>\$120,000</b>
Two-month internships for BCC staff from public and NGO sector to better understand the core elements of advertising from market research to creative design to product development and implementation. 6/year x Year 2, 3, 4, 5 = 24 internships x \$5,000	<b>\$120,000</b>
NGO staff time in support of district-level campaigns in each of the four technical areas. 168 interventions (8+40+40+40+40) using 400 volunteers for 20 days each x \$6/day =	<b>\$8,064,000</b>
Promotion of use of low-cost water filters produced by Indian companies, including commercial sales (see attached breakdown below)	<b>\$10,435,000</b>
Discount vouchers offering \$20 off the price of a commercial water filter will be funded by foundations, corporate social responsibility programs, or other donors and distributed to the poorest populations (50,000 vouchers x \$20 = \$1,000,000) Staff support from NGOs distributing the vouchers: \$30,000 Retailer support in redeeming vouchers: \$40,000	<b>\$1,000,000</b> <b>\$30,000</b> <b>\$40,000</b>
UP-wide introduction of new HIV/AIDS, FP/RH, TB, and MCH products and expansion of sales of all brands in partnership with manufacturers of these products meeting international specifications.	<b>\$16,377,000</b>
Obtain sponsors among communication agencies, telephone companies, and donors to hold annual awards for the best BCC programs implemented in India that year to increase the prominence of BCC and raise the professional profile of its practitioners. Promotion of the event by ad agencies, venue discount, and media coverage. \$75,000 x 4 years = \$300,000	<b>\$100,000</b> <b>\$200,000</b>
Health education materials on project's four interventions will be developed in collaboration with the Ministry of Secondary Education and Language and the Ministry of State of Basic, Adult and Non-Formal Education to update/revise new health education materials for elementary, secondary, and adult education. Use of project materials in health education teaching: UP has 123,540 schools 10 of 70 UP districts = 14.2% = 17,648 schools Assumption: Program reaches 80% of schools = 14,118 14,118 schools x 1 hour health education lesson/week x 30 weeks = 423,552 sessions/year of health education instruction related to project health areas \$6/session x 423,552 sessions = \$2,541,312/year x 3.5 years =	<b>\$8,894,592</b>

Description of Leverage Amount	Leverage Partner Investment
Expanding commercial sale of iron tablets by multiple brand owners in joint campaign to increase the consumption of iron tablets through increased promotion and availability of the product through expanded retail network..	<b>\$5,730,000</b>
Vouchers to be funded by various donors supporting MCH 310,000 vouchers for Year 2–5 x \$3 = \$930,000	<b>\$930,000</b>
NGO/government support in distributing vouchers: \$40,000 Retail outlets support in redeeming vouchers: \$60,000	<b>\$40,000</b> <b>\$60,000</b>
Expanding commercial sales of ORS packets and liquids by multiple brand owners in joint campaign to increase the use of ORS by families through increased promotion and product availability in local shops.	<b>\$1,162,600</b>
Work with the Secretariat of the Global Public-Private Partnership for Handwashing and Indian soap manufacturers to solicit resources for handwashing promotion, draw from their technical expertise in implementing large-scale handwashing behavior change campaigns, and bring the partnership's annual Global Handwashing Day awareness-raising campaign to UP. Year 1: \$50,000      Year 2: \$400,000      Years 3–5: \$600,000/yr	<b>\$2,250,000</b>
Collaborate with HUL's Swasthya Chetna, one of India's largest rural hygiene programs, which has reached more than 130 million people in 50,000 villages over the last 5 years. It includes a school program, use of digital media (mobiles) to reach mothers, mass media, and the use of Lifebuoy packaging to pass handwashing and other hygiene messages (700 million Indians buy a Lifebuoy at least once a year).	<b>\$5,000,000</b>

**AED Year I Work Plan**  
**Behavior Change Communication for Improving Healthy Behaviors Programs in India**

Key Activities		Outputs [with AMP Indicators]	Quarter				Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS
<b>Project Management</b>															
0.1	Initial meetings with GOI through USAID	Senior government officials are aware of project plans and activities and agree to project launch					GOI assigns a nodal person with MOWCD (secondary focus), MOHFW/IEC, RCH, RNTCP, and NACO for the project.	MOHFW – NRHM IEC (RCH and RNTCP) NACO – IEC, M&E Others – NHSRC, NIHFW, JSK, MOWCD	9 meetings	To be facilitated by USAID; contingent on USAID approval					
0.2	Initial meetings with GOUP through USAID	Senior government officials are aware of project plans and activities and agree to project launch					GOUP assigns a nodal person with DOWCD, RCH, RNTCP, and UPSACS for the project.	MOHFW – NRHM, DFV, DHS UPSACS – IEC, M&E Others – SIHFW, JSK, DOWCD	8 meetings	To be facilitated by USAID; contingent on USAID approval					
0.3	Hire project staff identified in bid and recruit other staff in Delhi, Lucknow, and in the districts	Hiring offer letters to selected applicants; USAID approval to staff selected for the project					Staff hired at national, state, and district levels.		National – 15 State – 21 District – 18	Recruitment process for district staff to start quarter 4	\$1,391	\$542	\$181	\$181	\$487
0.4	Set up and operate headquarters, Delhi, and Lucknow offices and procure office equipment and supplies	Leases signed; equipment purchased; phone, internet, fax lines operational; server, cars, drivers procured					Project offices open in Delhi and in Lucknow.		2 (one at national and at state each)	These costs are allocated among the four results					
0.5	Set up administration and financial systems	Administration and financial systems in place and finalized					Offices operational.		1 system	These costs are allocated among the four results					
0.6	Sign subcontracts or memorandums of understanding with resource partners in AED proposal	USAID approval, sub-contracts signed; memorandums signed with technical resource partners					Signed subcontracts with at least 3 of following organizations: Population Council, Population Services International (PSI), Project Concern International (PCI), Public Health Foundation of India (PHFI).		3 (one per partner)						
0.7	Conduct regular orientation meetings for AED project team	Meetings held					Staff technically and operationally ready to implement program.		3 meetings	Orientations (technical and administrative) to be conducted as staff get recruited at different times					

\* All costs are fully loaded for overhead and/or G&A, as appropriate. Costs include commitments not actual expenditures for the year.

Key Activities		Outputs [with AMP Indicators]	Quarter				Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS
0.8	Conduct meeting of project partners re AED/USAID procurement and financial guidelines, branding	Training held					Partners trained on AED/USAID guidelines and USAID branding.		1 meeting		\$1,391	\$542	\$181	\$181	\$487
0.9	Finalize annual work plan and AMP based on USAID comments	AMP designed; work plan finalized; next steps outlined					Project's Annual Work Plan (AWP) and AMP approved by USAID.		1 AWP + 1 AMP	TO deliverable in Year 1	\$1,391	\$542	\$181	\$181	\$487
0.10	Gather data, develop criteria, and finalize selection of districts for project implementation	Districts shortlisted and proposed to UP government for selection and approval					Districts selected for project implementation.		10 districts	Five districts shortlisted by USAID (to be revisited); district selection for IHBP will happen subsequent to USAID's internal process to finalize its priority districts in UP					
0.11	Review project progress with staff and project partners and plan for Year 2	Project review and planning meetings at national and state levels					Work plan and revision in AMP developed for next project year		4 (2 review meetings + 2 planning meeting)	Review meeting (national and state) in quarter 3; planning meeting (national and state) in quarter 4	\$41,733	\$16,276	\$5,425	\$5,425	\$14,607
<b>Subtotal 0.1-0.11</b>											<b>\$45,906</b>	<b>\$17,902</b>	<b>\$5,968</b>	<b>\$5,968</b>	<b>\$16,068</b>
0.12	Fixed Fee										\$2,525	\$985	\$328	\$328	\$884
<b>Total Project Management</b>											<b>\$48,431</b>	<b>\$18,887</b>	<b>\$6,296</b>	<b>\$6,296</b>	<b>\$16,952</b>
<b>I. IRI: Capacity Strengthened to Design, Deliver, and Evaluate Strategic Communication at National, State, and District Levels</b>															
1.1	In collaboration with USAID during initial encounters, conduct planning meetings with government partners and stakeholders in Delhi and Lucknow	Government inputs on technical documents, common areas in work plans, areas for TA and Year 2 activities [1.1.1, 1.3.1]					Identification of areas for TA and coordination of annual work plans.	MOHFW – IEC, NHSRC, JSK, RNTCP NACO – IEC SPMU-NRHM – IEC, MCH, RNTCP, RCH UPSACS – IEC, MOWCD/DOWCD	National – 12 meetings State – 12 meetings		\$13,911	\$5,425	\$1,808	\$1,808	\$4,870
1.2	Establish a PAG at national level consisting of representatives of relevant government departments, USAID partners, and BCC stakeholders	PAG meeting at national level [1.1.1, 1.1.2, 1.1.3]					Agreement of PAG on its SOW and its constituents.	MOHFW – IEC, MH, CH, RNTCP, RCH NACO – IEC, M&E, TI Others – NHSRC, NIHFW, JSK, MOWCD, UNICEF	1 meeting		\$6,956	\$2,713	\$904	\$904	\$2,435

Key Activities		Outputs [with AMP Indicators]	Quarter				Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS
1.3	Establish a SPAG consisting of representatives of relevant government departments, USAID partners, and BCC stakeholders	SPAG meeting at state level [1.1.1, 1.1.2, 1.1.3]					Agreement of SPAG on its SOW and its constituents.	SPMU-NRHM – IEC, MH, CH, RNTCP, FP, DFW, DHS UPSACS – IEC, M&E, TI, DOWCD Others – SIHFW, SIFPSA	1 meeting		\$6,956	\$2,713	\$904	\$904	\$2,435
1.4	Design and conduct an organizational needs assessment (formerly termed organization review) of HR, management practices, finance, monitoring, and data collection systems of BCC-related actions in MOHFW, NACO, MOWCD at national and state levels; part of the assessment will include questions on knowledge, attitudes, and skills of government staff about BCC systems to determine generic BCC capacity building needs	RFP for organizational needs assessment issued [1.1.1, 1.1.2, 1.1.3, 1.3.2]					Data collection instruments and plans developed that will lead to the identification of BCC capacity and practices, areas for improvement (HR, management practices, finance, technical capacity) and serves as part of the baseline for the institution strengthening component of the project.	MOHFW (with RNTCP NHRM, NIHFW, JSK) SPMU-NRHM (with DFW, DHS, SIHFW) NACO UPSACS, MOWCD/ DOWCD	5 (one report per organization at national and state level)	TO deliverable in Year 1 (will depend on 1.1)  Completion scheduled for Year 2  Government buy-in needed to conduct assessment  Organizational needs assessment is a term that better reflects the scope of the activity and will facilitate government buy-in	\$222,576	\$86,805	\$28,935	\$28,935	\$77,901
1.5	Undertake scoping study to identify nodal institutions at national and state levels	Scoping study report [1.5.1]					Nodal institutions identified at national and state levels.	MOHFW & NACO– IEC SPMU NRHM & UPSACS– IEC	2 (one each at national and state level)	Each agency at national and state level may decide to have a separate nodal institution to work with them	\$24,344	\$9,494	\$3,165	\$3,165	\$8,520
1.6	Participate in planning of NRHM-II, NACP-IV, RNTCP, and ICDS-IV, and strengthen the BCC and institution strengthening components	NRHM-II, NACP-IV, RNTCP, and ICDS-IV plans with higher prioritization of BCC in NRHM, NACP, RNTCP, and ICDS [1.1.2, 1.3.1, 1.3.2]					Increased focus (evidence-based strategy, implementation plan, and resource commitment) to BCC in NRHM, NACP, RNTCP, and ICDS.	MOHFW – RCH, RNTCP NACO – NACP SPMU-NRHM – RCH, RNTCP UPSACS – NACP MOWCD	2  1 2  1 1	This will continue into Year 2					

Key Activities		Outputs [with AMP Indicators]	Quarter		Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS	
1.7	Initiate baseline quantitative studies of government BCC staff at national and state levels, health providers, and frontline workers on: a) BCC processes and/or b) KAP on BCC and relevant health topics [in coordination with 1.8 and 4.1]	Request for proposal for research agencies/ consultants drafted; study design and tools drafted [1.1.1, 1.2.1]				Draft versions of study design and tools shared with partners and relevant stakeholders. Request for IRB approval initiated.	MOHFW & SPMU (NRHM) NACO & UPSACS MOWCD & DWCD	1 consolidated report plus separate reports per program element	TO deliverable in Year 2; needs approvals from relevant departments (including MOWCD and DWCD)  Completion in quarter 3/Year 2  Final design, release of RFP, and implementation is dependent on USAID/Government selection of districts	\$104,333	\$40,690	\$13,563	\$13,563	\$36,517
1.8	Initiate qualitative studies among health providers and frontline workers on: a) BCC processes b) KAP on health topics [in coordination with 1.7 and 4.1]	Request for proposal for research agencies/ consultants drafted; study design and tools drafted [1.1.1, 1.2.1, 1.2.2]				Draft versions of study design and tools shared with partners and relevant stakeholders. Request for IRB approval initiated.	MOHFW & SPMU (NRHM) NACO & UPSACS MOWCD & DWCD	1 consolidated report plus separate reports per program element	TO deliverable in Year 2; needs approvals from relevant departments (including MOWCD and DWCD)  Completion in Year 2  Qualitative studies will complement baseline as per 1.7 above.	\$69,555	\$27,126	\$9,042	\$9,042	\$24,345
1.9	Initiate performance needs assessment for VHSCs on BCC	RFP finalized [1.2.1, 1.2.2]				Research agency/ consultant bidders list finalized; study design finalized.	DHS – districts	TBD	RFP dependent on final selection of districts; will be completed in Year 2	\$83,466	\$32,552	\$10,851	\$10,851	\$29,212
1.10	Undertake an in-depth review of the existing MIS and M&E system within the MOHFW, MOWCD, and NACO, including systems from and to all levels; indicators and data entry formats; and quality control	Report on review of M&E for BCC within MOHFW, MOWCD, and NACO [1.3.2]				Contributes to M&E review by Technical Advisory Group.	MOHFW & SPMU (NRHM) NACO & UPSACS MOWCD & DWCD	1 report	This will supplement the organization needs assessment and provide more in-depth, comprehensive data useful in planning interventions to strengthen BCC in the MIS and M&E system of government	\$69,555	\$27,126	\$9,042	\$9,042	\$24,345

Key Activities		Outputs [with AMP Indicators]	Quarter				Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS			
1.11	Establish Technical Advisory Groups at national and state levels to advise on: a) Inputs for organizational needs assessment and identifying areas for improvement in government M&E vis-à-vis BCC b) A plan to address in-depth findings of the report generated in 1.10 on for BCC indicators, strategies, tools, and processes for M&E system in NRHM, ICDS (secondary focus), NACP, and RNTCP	Technical Advisory Groups established at national and state levels and one meeting held endorsed [1.3.2]					Increased consensus on areas of strengthening for monitoring and evaluating BCC; a draft list of additional BCC indicators, based on national/ international indicators, across thematic areas developed.	MOHFW & SPMU (NRHM) NACO & UPSACS MOWCD	I TAG  I TAG I TAG	TAG is envisioned as group to advise IHBP team on BCC and relevant program element vs. PAG which will be more strategic								
1.12	Introduce district level stakeholders to the project	Orientations planned for district-level meetings [1.2.3, 1.3.1]					District leadership understands the project and appoints a nodal person at the district for coordination.	District Health Society DAPCU	6 (one per district)	Implementation is dependent on final district selection	\$38,951	\$15,191	\$5,064	\$5,064	\$13,632			
<b>Deliverables for IR I (Field Costs)</b>		<b>Activities and Deliverables for IR I</b>											<b>Subtotal 1.1-1.12</b>	<b>\$640,603</b>	<b>\$249,835</b>	<b>\$83,278</b>	<b>\$83,278</b>	<b>\$224,212</b>
1.13	Local staff and consultants for IR I										\$609,767	\$237,809	\$79,270	\$79,270	\$213,418			
1.21	Home office staff and consultants for IR I										\$378,976	\$147,801	\$49,267	\$49,267	\$132,641			
		<b>Staff &amp; Consultants for IR I</b>											<b>Subtotal</b>	<b>\$988,743</b>	<b>\$385,610</b>	<b>\$128,537</b>	<b>\$128,537</b>	<b>\$346,059</b>
1.22	Local travel costs (including consultant travel)										\$118,349	\$46,156	\$15,385	\$15,385	\$41,423			
1.23	International travel costs (including consultant travel)										\$161,171	\$62,857	\$20,952	\$20,952	\$56,410			
		<b>Travel Costs for IR I</b>											<b>Subtotal</b>	<b>\$279,520</b>	<b>\$109,013</b>	<b>\$36,337</b>	<b>\$36,337</b>	<b>\$97,833</b>
1.24	Set up and operate headquarters, Delhi, and Lucknow offices and procure office equipment and supplies (IR I)										\$490,860	\$191,435	\$63,812	\$63,812	\$171,801			
1.25	Sign subcontracts or memorandums of understanding with partners in AED proposal (IR I)										\$96,855	\$37,773	\$12,591	\$12,591	\$33,900			
1.26	Fixed fee										\$137,312	\$53,552	\$17,851	\$17,851	\$48,058			

Key Activities	Outputs [with AMP Indicators]	Quarter	Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS			
<b>Total Costs for IR I</b>							<b>\$2,633,893</b>	<b>\$1,027,218</b>	<b>\$342,406</b>	<b>\$342,406</b>	<b>\$921,863</b>			
<b>2. IR 2: Accurate and Appropriate Knowledge/Attitudes Increased among Individuals, Families, Communities, and Providers at District, State, and National Levels</b>														
2.1	Review existing formative and quantitative research on all four program elements (HIV/AIDS, FP/RH, TB, MCH) and IEC/BCC materials currently used in the four health areas		Review report with recommendations [2.2.1, 2.2.2]			Focus behaviors identified for BCC strategy in the four program elements; areas for further formative, quantitative study identified.	MOHFW/SPMU-NRHM NACO/UPSACS	4 (one each for MCH, FP/RH, TB and HIV/AIDS)	Health topics within program element will be selected on basis of the topics from our TO and in consultation with the government	\$69,555	\$27,126	\$9,042	\$9,042	\$24,345
2.2	Review and document summaries of existing evidence on South Asia and national best practices in BCC		Summary of lessons from South Asia and national best practices in BCC; standard of evidence established for BCC [1.3.1, 2.2.1]			Lessons from the South Asia and national best practices is available for dissemination and replication.		1 reports		\$34,778	\$13,563	\$4,521	\$4,521	\$12,173
2.3	Initiate review of existing information, including Vistara and INHP projects, on VHNDs and other community BCC platforms, and undertake formative research (participant observation and other methodologies) on information gaps and implementation improvements identified		Desk review and formative research initiated [2.1.1, 2.1.2]			Identification on information gaps on BCC during VHND; identification of focus areas for BCC (messaging, capacity building, M&E) during VHND.	DFW and ICDS	1 report	Formative assessments will be conducted after districts are identified; will spill over to Year 2	\$55,644	\$21,701	\$7,234	\$7,234	\$19,475
2.4	Initiate baseline KAP survey of mothers, fathers/men, family members, community leaders on health areas [in coordination with 4.1]		Request for proposal for research agencies/consultants drafted; study design and tools drafted [2.2.1, 2.3.2, 2.3.3, 2.3.4, 2.3.5, 2.3.6]			Draft versions of study design and tools shared with partners and relevant stakeholders. Request for IRB approval initiated.	MOHFW & SPMU (NRHM) NACO & UPSACS MOWCD/DOWCD	1 consolidated report plus separate reports per program element	Need IRB approvals.  Bidding process to start after district selection is finalized.  Will spill over to Year 2	\$208,665	\$81,379	\$27,126	\$27,126	\$73,034
2.5	Review national and UP BCC Strategy for NRHM, NACP-III, ICDS, and RNTCP programs		Reports on review of national and UP BCC Strategy for NRHM, NACP-III, ICDS, and RNTCP [1.3.1, 2.2.2, 2.3.1, 2.4.1, 2.5.1, 2.5.2, 2.6.2]			Recommendations from the reviews are used to improve the BCC strategy for NRHM-II, NACP-IV, and RNTCP.	MOHFW – RCH (FP + MCH), RNTCP NACO – NACP SPMU (NRHM) – RCH (FP + MCH), RNTCP UPSACS – NACP MOWCD/DOWCD	2 reports  1 report 2 reports  1 report  1 report	This will be a desk review of existing documents that will be supplemented by interviews of government staff  Dissemination of findings and recommendations will happen in Year 2	\$55,644	\$21,701	\$7,234	\$7,234	\$19,475

Key Activities		Outputs [with AMP Indicators]	Quarter				Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS
2.6	Draft grant guidelines for selection of local organizations to facilitate community mobilization and community-level BCC activities	Draft grants guidelines available [2.4.2]					Draft grants guidelines shared with USAID/India.			Finalization of grant guidelines by quarter 1/Year 2; guidelines will include monitoring and reporting requirements of grants awarded					
<b>Deliverable for IR 2 (Field Costs)</b>		<b>Activities and Deliverables for IR 2</b>					<b>Subtotal 2.1–2.6</b>				<b>\$424,286</b>	<b>\$165,470</b>	<b>\$55,157</b>	<b>\$55,157</b>	<b>\$148,502</b>
2.7	Local staff and consultants for IR 2										\$284,542	\$110,971	\$36,990	\$36,990	\$99,591
2.8	Home office staff and consultants for IR 2										\$174,745	\$68,151	\$22,717	\$22,717	\$61,160
		<b>Staff &amp; Consultants for IR 2</b>					<b>Subtotal</b>				<b>\$459,287</b>	<b>\$179,122</b>	<b>\$59,707</b>	<b>\$59,707</b>	<b>\$160,751</b>
2.9	Local travel costs (including consultants travel)										\$46,546	\$18,153	\$6,051	\$6,051	\$16,291
2.10	International travel costs (including consultants travel)										\$71,632	\$27,937	\$9,312	\$9,312	\$25,071
		<b>Travel Costs for IR 2</b>					<b>Subtotal</b>				<b>\$118,178</b>	<b>\$46,090</b>	<b>\$15,363</b>	<b>\$15,363</b>	<b>\$41,362</b>
2.11	Set up and operate headquarters, Delhi, and Lucknow offices and procure office equipment and supplies (IR 2)										\$218,160	\$85,082	\$28,361	\$28,361	\$76,356
2.12	Sign subcontracts or memorandums of understanding with partners in AED proposal (IR2)										\$576,035	\$224,653	\$74,885	\$74,885	\$201,612
2.15	Fixed fee										\$98,777	\$38,523	\$12,841	\$12,841	\$34,572
<b>Total Costs for IR 2</b>											<b>\$1,894,723</b>	<b>\$738,940</b>	<b>\$246,314</b>	<b>\$246,314</b>	<b>\$663,155</b>
<b>3. IR 3: Community Platforms, Organizations, and Key Individuals (Influencers) Support Improved Health Behaviors</b>															
3.1	Initiate study to identify alliances and key stakeholders at national, state, and district levels; identify alliances and stakeholders to be strengthened	Report on review of alliances and key stakeholders at national, state, and district levels [3.1.1, 3.1.4, 3.2.1, 3.2.2]					Key alliances, organizations, and stakeholders identified to lead social/community mobilization activities.	MOHFW – RCH, RNTCP NACO – IEC SPMU-NRHM UPSACS MOWCD	3 (one each for national, state and district level)	TO deliverable in Year 1; district-level study will be conducted only after selection of districts and will likely be initiated in Year 2	\$55,644	\$21,701	\$7,234	\$7,234	\$19,475
3.2	Undertake media mapping at national and state levels	Media allies identified; areas for advocacy to media identified [3.1.1, 3.1.4, 3.4.1]					Will contribute to a media advocacy plan.		2 (one each for national and state level)		\$27,822	\$10,850	\$3,617	\$3,617	\$9,738

Key Activities		Outputs [with AMP Indicators]	Quarter				Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS	
3.3	Review and assess advocacy and community mobilization modules and materials (content, distribution, and use)	Consultant SOW defined to report on the review of modules and materials and provide recommendations for revision, new modules, and materials for advocacy [3.1.1, 3.1.2, 3.1.3, 3.3.1, 3.3.2, 3.3.3]					Information for development of improved materials and modules.		I report	Will spill over to Year 2	\$13,911	\$5,425	\$1,808	\$1,808	\$4,870	
	<b>Deliverable for IR 3 (Field Costs)</b>	<b>Activities and Deliverables for IR 3</b>							<b>Subtotal 3.1-3.3</b>			<b>\$97,377</b>	<b>\$37,976</b>	<b>\$12,659</b>	<b>\$12,659</b>	<b>\$34,083</b>
3.4	Local staff and consultants for IR 3										\$286,063	\$111,565	\$37,188	\$37,188	\$100,122	
3.5	Home office staff and consultants for IR 3										\$204,179	\$79,630	\$26,543	\$26,543	\$71,463	
		<b>Staff and Consultants for IR 3</b>							<b>Subtotal</b>			<b>\$490,242</b>	<b>\$191,195</b>	<b>\$63,731</b>	<b>\$63,731</b>	<b>\$171,585</b>
3.6	Local travel costs (including consultants travel)										\$38,500	\$15,015	\$5,005	\$5,005	\$13,475	
3.7	International travel costs (including consultants travel)										\$89,540	\$34,921	\$11,640	\$11,640	\$31,339	
		<b>Travel Costs for IR 3</b>							<b>Subtotal</b>			<b>\$128,040</b>	<b>\$49,936</b>	<b>\$16,645</b>	<b>\$16,645</b>	<b>\$44,814</b>
3.8	Set up and operate headquarters, Delhi, and Lucknow offices and procure office equipment and supplies (IR 3)										\$272,700	\$106,353	\$35,451	\$35,451	\$95,445	
3.9	Sign subcontracts or memorandums of understanding with partners in AED proposal (IR3)										\$576,035	\$224,653	\$74,885	\$74,885	\$201,612	
3.10	Fixed fee										\$86,042	\$33,557	\$11,185	\$11,185	\$30,115	
<b>Total Costs for IR 3</b>											<b>\$1,650,436</b>	<b>\$643,670</b>	<b>\$214,556</b>	<b>\$214,556</b>	<b>\$577,654</b>	

Key Activities		Outputs [with AMP Indicators]	Quarter			Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS
<b>4. IR 4: Vulnerable Communities Empowered to Seek Health Services and Products</b>														
4.1	Initiate baseline quantitative studies among health workers (health, ICDS, RNTCP), community-level stakeholders (PRI, VHSC), and HIV/AIDS, TB patients, women, and men to identify attitudes, beliefs, and practices re discrimination and stigma (in coordination with 1.7, 2.3, 4.2)	Request for proposal for research agencies/consultants drafted; study design and tools drafted [4.1.1, 4.2.1, 4.2.2, 4.3.1, 4.3.2, 4.4.1, 4.4.2]				Draft versions of study design and tools shared with partners and relevant stakeholders. Request for IRB approval initiated.	SPMU-NRHM (RCH, MCH, RNTCP) UPSACS MOWCD	1 consolidated report plus separate reports for key target groups	TO deliverable in Year 2  Need IRB approvals; funding for HIV/AIDS, TB, women research under IR 4; completion in Year 2; questions on stigma and discrimination will be included in baseline KAP to be conducted among target groups as per 1.7b and 2.4 above; separate studies will be conducted for key relevant target groups not covered in 1.7b and 2.4	\$83,466	\$32,552	\$10,851	\$10,851	\$29,212
4.2	Initiate qualitative studies among health workers (health, ICDS, RNTCP), community-level stakeholders (PRI, VHSC), and HIV/AIDS, TB patients, women, and men to probe attitudes, beliefs, and practices re discrimination and stigma (in coordination with 1.7, 2.3, 4.1)	Request for proposal for research agencies/consultants drafted; study design and tools drafted[4.1.1, 4.2.1, 4.2.2, 4.3.1, 4.3.2, 4.4.1, 4.4.2]				Draft versions of study design and tools shared with partners and relevant stakeholders.. Request for IRB approval initiated.	SPMU-NRHM (RCH, MCH, RNTCP) UPSACS MOWCD	1 consolidated report plus separate report for key target groups	TO deliverable in Year 2  Need IRB approvals; funding for HIV/AIDS, TB, women research under IR4; completion in Year 2	\$69,555	\$0	\$34,778	\$0	\$34,777
	<b>Deliverable for IR 4 (Field Costs)</b>	<b>Activities and Deliverables for IR 4</b>							<b>Subtotal 4.1–4.2</b>	<b>\$153,021</b>	<b>\$32,552</b>	<b>\$45,629</b>	<b>\$10,851</b>	<b>\$63,989</b>
4.3	Local staff and consultants for IR 4									\$121,798	\$47,501	\$15,834	\$15,834	\$42,629
4.4	Home office staff and consultants for IR 4									\$79,803	\$31,123	\$10,374	\$10,374	\$27,932
		<b>Staff &amp; Consultants for IR 4</b>							<b>Subtotal</b>	<b>\$201,601</b>	<b>\$78,624</b>	<b>\$26,208</b>	<b>\$26,208</b>	<b>\$70,561</b>

Key Activities		Outputs [with AMP Indicators]	Quarter				Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS	
4.5	Local travel costs (including consultants travel)									\$34,753	\$13,554	\$4,518	\$4,518	\$12,163		
4.6	International travel costs (including consultants travel)									\$35,816	\$13,968	\$4,656	\$4,656	\$12,536		
		<b>Travel Costs for IR 4</b>									<b>Subtotal</b>	<b>\$70,569</b>	<b>\$27,522</b>	<b>\$9,174</b>	<b>\$9,174</b>	<b>\$24,699</b>
4.7	Set up and operate headquarters, Delhi, and Lucknow offices and procure office equipment and supplies (IR 4)									\$109,079	\$42,541	\$14,180	\$14,180	\$38,178		
4.8	Sign subcontracts or memorandums of understanding with partners in AED proposal (IR4)									\$145,644	\$56,801	\$18,934	\$18,934	\$50,975		
4.10	Fixed fee									\$37,395	\$13,092	\$6,277	\$4,364	\$13,662		
											<b>Total Costs for IR 4</b>	<b>\$717,309</b>	<b>\$251,132</b>	<b>120,402</b>	<b>\$83,711</b>	<b>\$262,064</b>
<b>5. Cross-Cutting Result: Award Monitoring Plan and Knowledge Management</b>																
5.1	Operationalize the AMP and set up systems at state/district and national levels	Data, collected through routine systems, established at national and state/district levels					Project monitoring systems operational at national and state and district levels and reports generated quarterly.		2 reports (one at national and one at state level)	Actual data collection is under other results; reporting requirements are part of the subcontractors' subcontracts; grantees will have specific reporting requirement that will monitor activities under the grants program	\$34,778	\$13,563	\$4,521	\$4,521	\$12,173	
5.2	Develop a KM strategy for the project	KM strategy reviewed and finalized by the project team					KM strategy document will lay out the goal for knowledge sharing and provide all stakeholders access to information resources on relevant project topics.		1 strategy document	KM as a topic will be part of our institution strengthening plan						

Key Activities		Outputs [with AMP Indicators]	Quarter		Results	National Ministries, State Departments	Targets	Remarks	Budget (in US\$)*	FP/RH	TB	MCH	HIV/AIDS
5.3	Design and launch monthly newsletter and initiate preparations for project website	Newsletter launched; request for proposal for project website issued and agency for design selected, beta version of website launched				Design agency selected and beta version of website launched; newsletter launched in July 2011.	3 newsletters 1 website developed and approved by USAID for launch in first quarter of Year 2	Needs USAID approval	\$55,644	\$21,701	\$7,234	\$7,234	\$19,475
<b>Subtotal 5.1-5.3</b>									<b>\$90,422</b>	<b>\$35,264</b>	<b>\$11,755</b>	<b>\$11,755</b>	<b>\$31,648</b>
5.4	Fixed fee								\$4,973	\$1,939	\$647	\$647	\$1,740
<b>Total Costs for AMP and KM</b>									<b>\$95,395</b>	<b>\$37,203</b>	<b>\$12,402</b>	<b>\$12,402</b>	<b>\$33,388</b>
<b>6. Cross-Cutting Result: Leveraging and Public-Private Partnerships</b>													
6.1	Gather information to support PPP and leveraging	Information gathered to engage private sector to commit to PPP and leveraging				Evidence available on benefits of PPPs and leveraging for business sector.	1 report		\$27,822	\$10,850	\$3,617	\$3,617	\$9,738
6.2	Hold meetings with private sector on project and discuss potential collaboration	Meeting with FICCI, CII, and others cited in proposal conducted				Private sector oriented on project and collaboration discussed.	1 meeting		\$97,377	\$37,977	\$12,659	\$12,659	\$34,082
6.3	Develop private sector leveraging strategy for the project	Private Sector strategy reviewed and finalized by the project team				Private Sector leveraging strategy document.	1 strategy document						
6.4	PPP/leveraging consultants								\$28,170	\$10,986	\$3,662	\$3,662	\$9,860
<b>Subtotal 6.1-6.4</b>									<b>\$153,369</b>	<b>\$59,813</b>	<b>\$19,938</b>	<b>\$19,938</b>	<b>\$53,680</b>
6.5	Fixed fee								\$8,435	\$3,290	\$1,096	\$1,096	\$2,953
<b>Total Costs for Leveraging and Public-Private Partnerships</b>									<b>\$161,804</b>	<b>\$63,103</b>	<b>\$21,034</b>	<b>\$21,034</b>	<b>\$56,633</b>
<b>Total Cost</b>									<b>\$7,201,991</b>	<b>\$2,780,153</b>	<b>\$963,410</b>	<b>\$926,719</b>	<b>\$2,531,709</b>