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Behavior Change Communication Activities and Achievements

Lessons Learned, Best Practices and Promising Approaches

The Power of Innovations and Partnership

MARCH 2012

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END OF PROJECT SYMPOSIUM

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The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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FOREWORD

In the year 2000, India was home to more than one billion people, one-sixth of the word's population. The country's population is projected to increase by 60 percent, to 1.6 billion by the year 2050 (United Nations *World Population Prospects,* 2008). This large population and projected rate of growth present major challenges to health and resources for the world's largest democracy.

India has made significant strides in improving the health of its people. A reduction in fertility by 48 percent (from 5.2, 1972 to 2.7, 2005-06), and increase in contraceptive use of 38 percent (from 40.7, 1992-03 to 56.3, 2005-06) are indicators of progress. However, variances in health across sectors of the population, and prevailing rates of high fertility in northern states, such as Uttar Pradesh (UP), where fertility is 4.1 in rural areas (2005-06), highlight the need for continued efforts on family planning (FP) and reproductive health (RH) programs to improve health.

From 2004-10 the United States Agency for International Development (USAID) and the Government of India delivered innovative initiatives to expand access to FP/RH products and services among underserved populations through the Innovations in Family Planning Services-II (IFPS-II) project, a follow-up from the successful bilateral IFPS-I project (1992-04).

Under IFPS-II, behavior change communication (BCC) strategies were employed to generate demand for the uptake of FP/RH products and services to improve health among populations with low access to such services in UP, Uttarakhand and Jharkhand. BCC initiatives were developed and delivered in collaboration with key stakeholders – the National Rural Health Mission (NRHM); State Innovations in Family Planning Services Agency (SIFPSA); Government of India; Government of UP, Uttarakhand and Jharkhand; and district and block health program workers. BCC strategies have now become integral to India's Program Implementation Plans under the NRHM, and have positively influenced health programs from state level development through program managers, to community level delivery through frontline health workers across the country.

This document presents lessons learned, best practices and promising approaches of the BCC initiatives developed and delivered under IFPS-II. It seeks to provide a reference, along with insights and guidance, to policymakers, program planners, and implementers to contribute to achieving the goals of the country through improved health of women, children, families and communities.

Sincerely,

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This report is a second edition of the "Behavior Change Communication Activities and Achievements: Lessons Learned, Best Practices and Promising Approaches", dated June 2010. It now includes the additional activities carried out between June 2010 to March 2012.

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ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AVC	Assistant Voucher Coordinator
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BCIS	Behavior Change Impact Survey
BHC	Block Health Center
BISR	Birla Institute of Scientific Research
BPL	Below Poverty Line
BPM	Block Program Manager
CBHI	Central Bureau of Health Intelligence
CH	Child Health
CHC	Community Health Center
CHV	Community Health Volunteer
CINI	Child in Need Institute
CMO	Chief Medical Officer
CPR	Contraceptive Prevalence Rate
DAVP	Directorate of Advertising and Visual Publicity
DCM	District Community Mobilizer
DHEO	District Health Education Officer
DLHS	District Level Household and Facility Survey
EAG	Empowered Action Group (states)
EE	Entertainment-Education
FP	Family Planning
FWC	Family Welfare Counselor
GoI	Government of India
HEO	Health Education Officer
HIHT	Himalayan Institute of Health Training
HIV	Human Immunodeficiency Virus

ICDS	Integrated Child Development Services Scheme
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IFPS	Innovations in Family Planning Services
IPC/C	Interpersonal Communication/Counseling
IPHS	Indian Public Health Standards
IRH	Institute for Reproductive Health
ITAP	IFPS Technical Assistance Project
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
JHS	Jharkhand Health Society
JHUCCP	Johns Hopkins University Center for Communication Programs
JSK	Jansankhya Sthirata Kosh
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
MCH-STAR	Maternal and Child Health-Sustainable Technical Assistance and Research Project
MGHN	Merry Gold Health Network
MH	Maternal Health
MHV	Mobile Health Van
MIS	Management Information System
MoHFW	Ministry of Health and Family Welfare
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NHSRC	National Health Systems Resource Center
NIC	National Informatics Center
NRHM	National Rural Health Mission
NRS	National Readership Survey
NSV	No-scalpel Vasectomy
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Solution
OTS	Opportunity to See
PFI	Population Foundation of India
PHC	Primary Health Center
PIP	Program Implementation Plan
PMU	Program Management Unit
PNC	Postnatal Care

PPFP	Post Partum Family Planning
PPP	Public-Private Partnership
PPS	Population Proportion to Size
PRI	Panchayati Raj Institute
PSU	Primary Sampling Unit
PTG	Primitive Tribal Group
RCH	Reproductive and Child Health
RH	Reproductive Health
RKS	Rogi Kalyan Samiti
RMP	Registered Medical Practitioner
RTI	Reproductive Tract Infection
SDM	Standard Days Method
SIFPSA	State Innovations in Family Planning Services Agency
SIHFW	State Institute of Health and Family Welfare
SSK Yojana	Saloni Swasth Kishori Yojana
STI	Sexually Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities and Threats
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TOT	Training of Trainers
TRP	Television Rating Points
UDAAN	Understanding and Delivering to Address Adolescent Needs
UKHFWS	Uttarakhand Health and Family Welfare Society
UP	Uttar Pradesh
USAID	United States Agency for International Development
VHSC	Village Health and Sanitation Committee
VMA	Voucher Management Agency
WHO	World Health Organization

INTRODUCTION

INNOVATIONS IN FAMILY PLANNING SERVICES

Launched in 1992, Innovations in Family Planning Services (IFPS) was an ambitious 12-year bilateral project funded by the United States Agency for International Development (USAID) that expanded and improved family planning (FP) and reproductive and child health (RCH) services in Uttar Pradesh (UP), India's most populous state. IFPS achieved many milestones and made significant contributions to the health of women, children and families in UP. Major achievements include the development of an autonomous agency to oversee management of activities: the State Innovations in Family Planning Services Agency (SIFPSA); a strengthened public healthcare system for the provision of FP and RCH services through technical assistance, training and capacity building; engagement of the private sector to bring FP and RCH services to rural and hard-to-reach populations; and increased access to products and services through social marketing and behavior change communication (BCC).Technical assistance has been provided by a consortium of agencies under the IFPS Technical Assistance Project (ITAP), led by the Futures Group International, in partnership with the Johns Hopkins University Center for Communication Programs (JHUCCP), Bearing Point, QED Group and the Urban Institute. The program aims to develop, demonstrate, document and leverage the expansion of public-private partnerships (PPPs) for the provision of high quality FP, RH and child health services to improve health outcomes in the region. The project developed and demonstrated models of PPPs including: development of conditional cash transfers like the Voucher Scheme, social franchising of the Merrygold Health Network (MGHN), expansion of a basket of contraceptive products, promotion of mobile health services, and collaboration with traditional medical providers in tribal communities. Through these activities, the project developed, demonstrated, documented, disseminated and leveraged expansion of effective partnership models. In Uttar Pradesh, Jharkhand and Uttarakhand, the IFPS project implements BCC and marketing strategies to increase demand for FP and RH services and products.

Background

Family planning and reproductive health have been the priority health areas in India for more than three decades. Many programs have been implemented to increase access to, awareness and use of RH/FP products and services. The programs have made progress in this direction with the overall population growth rate declining from 2.2 percent in 1990 to 1.5 percent in 2006. Similarly, total fertility decreased from four children per woman in 1990 to 2.6 children per woman in 2006.[1]

The IFPS project focused on UP, Jharkhand and Uttarakhand, though special attention has been paid to UP due to the severity of indicators.

Reducing Fertility and Improving Health

Since its inception in 1992, the IFPS project aimed to reduce fertility and improve health in targeted areas of India by increasing the

TABLE 1: NFHS-3 DATA FINDINGS (INDIA AND STATES)

NFHS-3 (2005-06)	All India	UP	Uttarakhand	Jharkhand
CPR (any method) (%)	56.3	43.6	59.3	35.7
TFR	2.68	3.82	2.55	3.31
ANC (3+ visits) (%)	52.0	26.6	44.9	35.9
Institutional delivery (%)	38.7	20.6	32.6	18.3
Full immunization (12-23 months) (%)	43.5	60.0	34.2	46.6

[1] World Health Organization, WHO Statistical Information Systems, 2010

demand for and uptake of FP and RH services, and by increasing the use of behavioral interventions for Human Immunodeficiency Virus (HIV) prevention, maternal health, child survival and infectious disease. The main goal was to reduce total fertility rate (TFR) and increase the contraceptive prevalence rate (CPR) in married women of reproductive age by 50 percent (USAID/India, 1992). By addressing total fertility and contraceptive use with the integration of the underlying factors of maternal health (MH), child health (CH) and nutritional health, IFPS project has made many great strides that are presented in this report.

BEHAVIOR CHANGE COMMUNICATION

Goals of BCC for IFPS Project

Overall, the primary objective of the project was to achieve the following with the close support and integration of BCC:

- Incorporate best practices in RCH when models of PPP are developed, demonstrated and documented.
- Form linkages with Indian technical organizations to deepen the already strong national capacity for international quality technical assistance.
- Assist in the establishment and nurturing of the National Health Systems Resource Center (NHSRC) (see further details below).
- Develop the capacity of the state and national public sector to enter into partnerships with the private sector.
- Incorporate sustainability considerations and replication strategies into models and systems from the outset and to bring these models to scale with resources from other sources.
- Facilitate collaboration between public and private sectors in efforts to address FP and RH needs.
- Ensure high standards of care.
- Build capacity of local organizations to meet the needs of their communities.
- Increase the use of research to refine and improve program approaches.

Strategic approaches to BCC

The BCC strategy for the National Rural Health Mission (NRHM) began with the prioritization of behaviors for change based on individual health needs in each of the three target states. With this information, a roadmap of interventions was assimilated, designed and implemented to address those needs through state, district and block level program managers.

Key elements of the BCC strategy:

- Address priority behaviors and targeted interventions for the most critical health needs.
- Deliver activities and interventions through converging channels of communication.
- Coordinate and deliver implementation plan for interventions in districts and blocks across the three states through health program managers and workers at all levels.

This strategy recognized the importance of using a mix of media to reinforce messages and ensure sustainable behavior change. The core of the strategy revolved around: (1) interpersonal communication (IPC) and community level BCC activities, with support from (2) mass media and (3) community mobilization. The IFPS project and NRHM worked together with other stakeholders to select five core health areas for intended behavior change. All interventions and activities delivered through IPC and community events, community mobilization, and mass media are coordinated and focused accordingly to achieve the overarching objectives. By following this schedule annually, community-based activities were coordinated with state level mass media efforts, and IPC efforts through local health workers, thereby reinforcing messages and supporting behavior change at both community and household levels.

National level

At the national level, the IFPS project has provided technical assistance to the NRHM and the Ministry of Health and Family Welfare (MoHFW) for designing of mass media campaigns on RCH and FP issues using the behavior change approach, and as a key technical resource and advisor on BCC, FP and adolescent health for upcoming projects and schemes that the MoHFW plans to launch.

Uttar Pradesh

BCC activities in UP culminated in the development of a BCC strategy for the NRHM and a companion implementation guide for district and block level health program managers addressing priority health behaviors. Numerous BCC activities were developed to increase knowledge and awareness of, and demand for FP/RH products and services. Additional activities were conducted to advocate for improved

TABLE 2: BCC – INTENDED OUTCOMES

	Strategy Development	BCC Campaigns/Material Development			BCC Capacity Building	BCC in Social Marketing/ Franchising
		Mass media	Mid-media	IPC/ Community Level		
National		Campaign 2004–09 Campaign 2009–10 (3 phases) NRHM advocacy film Atmajaa Tele Series Promotion of JSK Call Center Menstrual Hygiene campaign IUCD campaign		'ASHA se maango' campaign	National IEC/ BCC Workshop	
Uttar Pradesh	NRHM BCC Strategy 2008	Multimedia Sterilization campaign 2004 Radio Series – *Sunehere Sapne-Sanwarti Rahein*	Comprehensive Poster on Family Planning ASHA Newsletter Immunization – *jachcha-bachcha raksha card* Folk Media–Street plays, puppet and magic shows	Saloni Diary	Distance Learning Program NRHM Flipbook for ASHA Saloni Teachers' Training Manual Family Welfare Counselors Training Module Regional BCC capacity building	Communication Plan for MGHN Brand Equity and Barrier Analysis Study Voucher Scheme
Uttarakhand	BCC strategies for specific programs: • Mobile Health Vans • Voucher Scheme • Adolescent Health	Institutional Delivery campaign Immunization campaign Sambhav Voucher Scheme Promotional Campaign	UDAAN-Adolescent Health Program Voucher Scheme Demand Generation Mobile Health Van Demand generation	ASHA Plus Program		
Jharkhand	Health Communication Strategy Health Issues and Health Seeking Behaviors of Tribal Populations BCC Strategy for Voucher Scheme	Spacing campaign Institutional Delivery campaign	Voucher Scheme Demand Generation Street Play campaign	IPC toolkit for Sahiyyas (ASHAs)	Intra-communication	

service access and utilization, and to build capacity among mid-level health program managers within the state, districts, blocks and frontline healthcare workers such as accredited social health activists (ASHAs) and auxiliary nurse midwives (ANMs). Activities delivered in UP engaged the private sector and employed mass media, entertainment-education (EE), community mobilization and capacity building strategies.

Uttarakhand

BCC activities undertaken by the IFPS project began in Uttarakhand in 2004. To improve the effectiveness of existing BCC programs for FP and RCH services, the IFPS project provided technical assistance through ITAP on an activity-by-activity basis. Utilizing this approach, the IFPS project in collaboration with the Government of Uttarakhand, developed BCC to support various PPP initiatives including Mobile Health Vans (MHVs), FP and RCH Voucher Schemes, and pilot programs like adolescent health and the ASHA Plus program. All of these programs began as pilot projects, and most models were subsequently adopted by the Uttarakhand Health Society, and scaled up to reach more families and communities. The need still exists in Uttarakhand for an overarching BCC strategy to improve health in this remote and mountainous region of India.

Jharkhand

BCC activities undertaken by the IFPS project began in Jharkhand in 2004. To improve the health of populations, the IFPS project assisted in the development of a statewide BCC strategy for priority health areas, with special emphasis on the needs of tribal populations unique to the region. Attention was given to improving capacity for intra-communication across stakeholders, and IPC of *sahiyyas* and community health workers. Additionally, generating demand for FP and RCH services available through government schemes was important. To generate this demand for FP products and services, the IFPS project implemented the Sambhav Voucher Scheme through its technical assistance project ITAP as a PPP initiative for which a range of BCC materials were developed.

SECTION I

Behavior Change Communication

National Level

The Power of Innovations and Partnership

Section 1 *National Level*

BEHAVIOR CHANGE COMMUNICATION

BCC activities undertaken by the IFPS project at the national level focused on FP and RCH, with emphasis in UP, Uttarakhand and Jharkhand following evidence-based strategic approaches to health communication. BCC program components at the national level consisted of information, education and communication (IEC)/BCC, mass media, assessment, sustainable BCC development, capacity building, EE and advocacy with the goal of increasing awareness and knowledge, improving attitudes, generating demand and positively changing behaviors related to FP and RCH.

With the launch of the NRHM in 2005, the IFPS project, through ITAP, provided all pre-2005 BCC materials to the NRHM and the MoHFW for broad dissemination throughout the states and districts. Between 2005 and 2009, the IFPS project managed the development of various BCC campaigns that focused on FP and RCH through IEC and BCC for distribution through mass media outlets (TV, radio and print). Starting in June 2009, a roadmap for a three-phase national mass media campaign to reinforce initial IEC and BCC messages was laid out for creation and dissemination in

May 2010. Other activities conducted at the national level include a study on assessing visibility, comprehension and recall of TV campaigns aired under the NRHM; capacity building through a national IEC workshop; *Atmajaa*, a TV serial drama; and an NRHM advocacy film. In 2010–11, the IFPS project designed two mass media campaigns, one for the promotion of the Population Stabilization Fund (JSK) call center services and a campaign on Menstrual Hygiene for the promotion of socially marketed sanitary napkin brand for the MoHFW.

MASS MEDIA

Since the launch of the NRHM in 2005, the IFPS project has been recognized as the technical leader in the area of BCC campaign and material development. The IFPS project assisted the NRHM in creating a range of TV and radio spots on priority health themes including FP, age at marriage, the role of the NRHM in promoting health and preventing disease, HIV/AIDS, antenatal care (ANC) and immunization. The IFPS project also developed over 20 TV and radio spots for the NRHM which aired on cable and satellite channels in India over two phases between 2005 and 2009. The TV and radio spots largely relied on promoting benefits and addressing barriers to behavior change and employing role models based on social and behavioral theories to trigger positive change.

NRHM BCC CAMPAIGN – PHASE I

In this first phase, the IFPS project created TV and radio spots for the NRHM from May through October 2006. Some TV spots were exclusively designed for and aired by MoHFW, while others were developed and aired under other programs.

Strategic Approach and Objectives: Empowerment through the use of role models, promotion of behaviors and benefits, and addressing barriers, audiences are motivated to improve attitudes towards and adopt positive behaviors for age at marriage, ANC, WHO-ORS, immunization, FP and HIV/AIDS.

Audience: Couples 20–45 years of age and adolescents 15–19 years old, largely in rural areas.

Creative Approach: A range of approaches were employed in the NRHM BCC campaign. Some spots used celebrities from Indian cinema and television to share how the adoption of positive health behaviors impacted their lives, thereby encouraging audiences to also adopt healthy behaviors for better health and quality of life. Other spots employed emotional approaches, pulling from cultural and social traditions such as festivals and customs that are rooted in Indian history.

Results: A study on the Visibility, Comprehension and Recall of TV spots aired under NRHM was carried out in 2007 by an independent research agency to gauge the impact of the spots that were aired nationally on Doordarshan, Indian's largest TV channel, along with a range of satellite channels.

Survey Objectives: The main objective of this study was to assess the reach and effect of the TV spots on the target audience. Findings from this survey helped inform the future directions of the NRHM BCC efforts. The specific objectives of the study were to obtain information on the following:

Visibility

- Reach and exposure of the specified NRHM spots
- Sources of seeing or hearing (channel, time of program)

Comprehension and Relevance

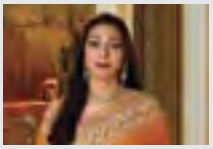
- Awareness regarding NRHM logo
- Recall – the contents of NRHM spots
- Recall – main messages communicated through NRHM spots
- Relevance and acceptability of the messages

Design: The study followed a two-stage stratified systematic random sampling design. At the first stage, 213 primary sampling units (PSUs), i.e., villages/urban wards were selected through the Population Proportion to Size (PPS) technique in eight Empowered Action Group (EAG) states. At the second stage, interviews were conducted with 3,500 households that were selected in villages and urban wards by means of a systematic random sampling procedure. The number of participants interviewed in the selected households is as follows:

- 1,496 married men aged 20–45 years
- 1,588 married women aged 20–45 years
- 779 adolescent boys aged 15–19 years
- 791 adolescent girls aged 15–19 years

Findings: The selection of health themes for the campaign was largely in line with the three broad goals of

TABLE 3: TV SPOTS DEVELOPED DURING NRHM BCC CAMPAIGN (PHASE I)

Theme/Objective	TV Spot	Study Findings
Age at marriage		
Encourage completing school and delay marriage until 18 years of age	Emotional black-and-white ad Celebrity ads: Amitabh Bachchan Raveena Tandon	Among the three TV spots on age at marriage, the black and white ad had maximum recall compared with the Raveena Tandon or Amitabh Bachchan ads in color. This is true in the case of both rural and urban areas and also among the four segments of the target populations (currently married women & men; adolescents girls & boys). This clearly shows that the innovative treatment of the message very effectively broke through the clutter.
ANC		
Benefits and the role of ASHAs and ANMs 	'Afternoon gossip' with pregnant woman Celebrity ads: Juhi Chawla Pallavi Joshi Supriya Amitabh Bachchan	Under the NRHM TV campaign, there were five spots on ANC that USAID supported. Spontaneous recall of these ads was very low both in rural and urban areas. Recall increased marginally after probing and with aiding, an increase is noticed. Overall, among currently married women, the ad by Pallavi Joshi has the maximum overall recall 33 percent in rural areas and 46 percent in urban area — with "Afternoon Gossip" coming second (25% in rural and 41% in urban areas). Among currently married men, however, the Amitabh Bachchan ad topped the list in rural areas (24%) and "Afternoon Gossip" topped the list in urban areas (30%) with the Amitabh Bachchan ad coming in a close second. As with currently married women, among adolescent girls as well as adolescent boys, the Pallavi Joshi ad, followed by "Afternoon Gossip" had best overall recall.
WHO ORS		
Benefits and preparation	'School teacher' diarrhea ad Prevent recurring diarrhea – ORS and zinc Celebrity ads: Sakshi Tanwar Chef Sanjeev Kapoor	The WHO-ORS spot has a better reach among women and adolescent girls in the community than the immunization ads. Almost 56 percent of the currently married women in rural areas have reportedly seen the WHO-ORS ad, and the proportion increases to 66 percent in case of urban areas. The proportion of adolescent girls who reportedly saw this ad was 48 percent in rural and 70 percent in urban areas. A similar pattern was documented in currently married men and adolescent boys.
Full Immunization		
	Celebrity ads: Amitabh Bachchan Pallavi Joshi	The Amitabh Bachchan ad on immunization had a better spontaneous recall than the one by Pallavi Joshi. Around 7-8 percent of the women and adolescent girls, and 11–18 percent of men and adolescent boys, respectively, reported having seen the spot. However, with probing and aided questioning, a higher proportion of women and adolescent girls reported having seen Pallavi Joshi's ad on immunization as compared to Amitabh's.
HIV/AIDS prevention		
	Celebrity ad: Amitabh Bachchan	These spots were not evaluated.
NRHM programs		
	Role and services of ASHAs JSY (Safe Motherhood scheme)	These spots were not evaluated.

the GoI's RCH-II program of reducing fertility, infant mortality and maternal mortality.

- Ownership of a functional TV varied from 23 percent in rural households to 57 percent in urban households
- TV viewership was high among men both in rural and urban areas
- Overall, nearly three-fifths of respondents in each of the target audiences who were exposed to the ads found them to be effective in conveying the intended message
- In general, a higher proportion of married men and adolescent boys than married women and adolescent girls attempted to take some type of action after seeing the TV spots. This is not surprising, as numerous studies have shown that women often are not empowered to make decisions about their own health and the health of their children.

Specific actions included:

- gathering more information on an issue after seeing a spot on it; and
- encouraging friends, relatives or others to follow the behaviors, or following the behaviors communicated through the ad for themselves, their spouse, their family members or children.

The impact of the FP ad is seen by actions taken by married respondents where 58 percent of married men and 46 percent of married women reported that they started using a FP method after seeing the ads.

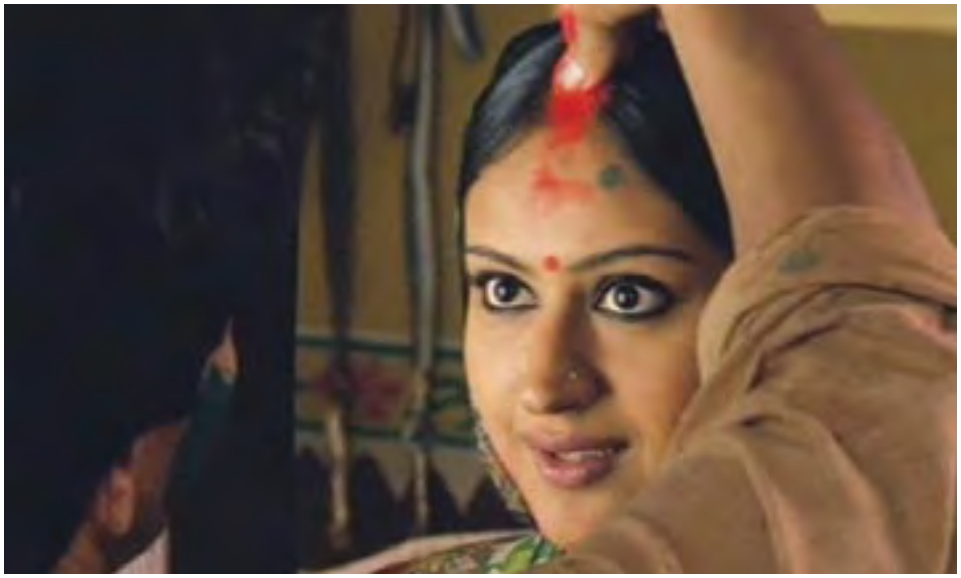
Visibility/Recall of TV Spots: An assessment of the recall of the TV spots was done at three levels: a) spontaneously; b) after some prompting; and c) after aiding the respondent by narrating the key aspects of the TV spot.

Recommendations for Future Mass Media Campaigns

- As RCH-II service delivery is strengthened, the thematic areas for BCC will need to be expanded. However, this should be done within an overarching evidence-based BCC strategic framework. The BCC strategy should be implemented in phases so that efforts are focused and lead to desired behavior change. Too many messages aired less frequently can lead to message dilution.
- Findings from the evaluation indicate that recall and comprehension of the TV spots vary by health theme and creative approach. This highlights the importance of audience segmentation for message design as well as media placement. The third round of the National Family Health Survey (NFHS-3) and the National Readership Survey (NRS) can be excellent data sources for this purpose.
- Another aspect related to audience segmentation is the choice of media channels. Though TV is an important and effective medium, reach among rural audiences in EAG states is limited, albeit growing. For behavior change to occur, TV should be supplemented with other BCC channels including community outreach and IPC.
- The celebrity spots had varying impact with different audiences and health themes. The evaluation also demonstrated that non-celebrity spots can work equally well, if not better than celebrity spots.
- Sustained airing of TV spots is important. Several spots that had higher recall had also been aired through multiple programs, increasing their exposure and subsequently their recall.

NRHM BCC CAMPAIGN – PHASE II

The second phase of the NRHM's BCC campaign was implemented nationwide by the MoHFW, Government of India from 27 December, 2008 to 26 January, 2009. The focus of this campaign was to promote existing programs and schemes, improve attitudes towards and increase knowledge on key maternal, newborn, child health and nutrition interventions and behaviors. The campaign aired 16 television spots and seven radio spots in Hindi and released print ads in major newspapers nationwide. The IFPS project provided BCC content for the campaign, and development partners including USAID, UNICEF and UNFPA participated in its implementation.



Strategic Approach and Objectives: Through empowerment, role modeling and promotion of FP choices and benefits:

- motivate audiences to adopt positive FP and RCH behaviors by addressing key factors that act as enablers and barriers to adoption; and
- improve attitudes towards FP and RCH among intended audiences across focused health themes.

Audience: General population, 15–45 years of age.

Creative Approach: A range of creative approaches were used, including the use of cultural symbols, festivals and customs that are rooted in traditions of everyday life, as well as emotionally inspiring lyrics and visuals. This campaign called for promoting health services and schemes of the NRHM and positioning the ASHA as an important link between health services and families. To achieve this, some spots showcased the high quality of health services and presented them as within the reach of families through the ASHA. In a few spots, celebrities from Indian cinema and television shared how their lives were improved by adopting positive health behaviors and appealed to audiences to also adopt healthy behaviors for better health and quality of life.

Interventions and Activities: Sixteen television spots, seven radio spots and numerous print ads across all major national newspapers were developed, focusing on age of marriage, FP adoption and the NRHM.

Results: An independent study of the reach, recall, comprehension, appeal and intention-to-act was commissioned by USAID and carried out by Population Foundation of India (PFI) and MCH STAR[2]. The evaluation determined the extent of the campaign's reach, visibility and exposure among the target audiences as also the recall, comprehension and appeal of specific spots of the campaign. Further, the evaluation aimed to provide relevant recommendations to MoHFW to enhance the effectiveness of future, large scale behavior change campaigns. The evaluation represented urban and rural areas of 11 high focused states and other states across the country and surveyed 3,575 currently married women (15–29 years of age), 1,784 husbands of women (15–29 years of age) and 350 fathers and mothers-in-law. In-depth discussions were held with state level policymakers

[2] A Concurrent Evaluation of Phase II of the NRHM BCC Campaign (2009)- MCH STAR, PFI

and program managers, and with 30 state, 54 district and 120 block level officials and health service providers at grassroots level to elicit their perceptions of and recommendations for improving the campaign.

Key Findings: The key findings of this concurrent evaluation included:

- Television has a much greater reach than radio in all locations.
- The TV spots used in the campaign appealed to most of the respondents (70-95%) who were exposed to them.

TABLE 4: KEY RESULTS OF NRHM BCC CAMPAIGN (PHASE II) CAMPAIGN EVALUATION

	Key Message and Creative Approach		Study findings (in percentages)				
			Message Recall	Compre-hension	Likeability	Gained new knowledge	Intend to take action
Age at marriage	Emotional appeal to girls to delay marriage until 18 years	Women	81.6	92.1	87.5	65.3	48.7
		Men	83.5	91.4	89.5	61.6	60
Family Planning	Celebrity couple Sachin and Supriya encourage couples to adopt FP by sharing personal experiences	Women	41.2	94.4	89.8	68.6	48.3
		Men	41.4	94.9	88.8	67.4	59.4
	Celebrity Juhi Chawla encourages couples to adopt FP for child spacing and limiting to have a small but healthy family	Women	40.3	89.1	87.4	70.1	41.2
		Men	57	88.5	82.6	67.1	40.6
	Women discuss contraception choices while applying *mehendi* or henna, in a cultural setting	Women	50	88.0	87.2	64.7	41
		Men	40	89	87.2	66.4	58
	Married couples discuss IUD as a FP method at the Holi festival, a festival of colors that symbolizes the joys of life	Women	41	92.6	87.8	67.1	42.5
		Men	25	85.8	70	79.7	41.1
NRHM	Medical tour of services and schemes, and ASHA as the link to the health system through the eyes of a medical student	Women	36.5	91.3	88	63.4	43.7
		Men	41.9	95.7	84.5	54	38.5
	A New Day, A New Sky: third-person view of the reach and impact of NRHM on families	Women	29.2	84.7	83.6	73.6	43.1
		Men	30	93.4	95.2	81.1	66.2
	Celebrity couple promotes ANC, involvement of men in decisionmaking, and communication between husbands and wives	Women	26.6	88.5	86.7	63.6	44.1
		Men	40.5	78.1	88.2	72.4	55.1
	Celebrity Juhi Chawla promotes ANC and shares her personal experiences	Women	33.1	88.2	86.3	68.4	53.9
		Men	35.3	87.2	88.9	75.5	47.8

N = 3,575 married women
1,784 husbands
350 fathers and mothers-in-law

- The radio spots used in the campaign appealed to most of the respondents (73-90%) who were exposed to them.
- Creative and entertaining TV spots, without celebrities, can have as much recall, comprehension and appeal as spots featuring famous celebrities.
- Overall, language was not a major barrier to comprehension and appeal of the spots, though the campaign was done only in Hindi. The few who reported difficulties with the language in the spots were from other states, where Hindi is not the major language spoken.
- A significant proportion of respondents exposed to the TV spots — 32 to 72 percent of men and 40 to 55 percent of women — intended to take action as a result of the campaign including discussing the topic with their spouse, family members and friends. This included seeking services promoted in the spots and following specific practices based on messages in the spots. Mothers-in-law discussed the contents of the spots with daughters-in-law.
- Other major sources of information on the themes of the campaign among both men and women were ANMs, ASHAs, *anganwadi workers* (AWWs) and relatives.
- Policy makers and program managers recommended that messages in print media should avoid 'information overload', difficult words, jargon, and photographs of politicians; it should have a regional flavor for maximum effectiveness; and include complementary IPC efforts.

NEW FAMILY PLANNING MASS MEDIA CAMPAIGN

In 2009, the MoHFW requested renewed campaigns on FP, CH and MH, with emphasis on birth spacing. A three-phase mass media campaign for 2009–10 to be rolled out on a quarterly schedule was designed to build on previous mass media messages, while outlining specific milestones for media creation. Based on data from the NFHS-3 and the District Level Household and Facility Survey (DLHS, 2005-06), gaps in FP knowledge and behavior persist, including knowledge and use of modern contraceptive methods, birth intervals and men's attitudes toward contraception. This mass media campaign aimed to reinforce IEC/BCC messages from 2005 through 2009, reach a broader audience with new messages, and address the most pertinent gaps in a systematic and consecutive way.

Strategic Approach and Objectives: To improve health of families by increasing knowledge and positively impacting attitudes and behaviors related to FP and RCH through mass media and involvement of men in decision-making, in particular, to re-position modern FP methods as health preserving and health promoting for mothers and children.

- Promote FP, with specific focus on birth spacing and postpartum contraception.
- Improve communication between husbands and wives, and involve men in decision-making.

Creative Approach: The FP campaign for 2009–10 placed particular focus on birth spacing and postpartum FP, and on repositioning BCC in the context of adopting modern methods for healthier mothers and children. This campaign called for the promotion of FP, especially spacing methods, among newlyweds and women with one child. There was also a need to promote FP methods other than female sterilization, which has been the most popular method adopted by women.

Participation of men in FP decision-making was a key objective of this campaign, which shifted the focus to men by highlighting their important role. All TV and radio spots had visuals and dialogues that encouraged men's participation in FP decision-making.

Some of the central creative approaches included:

- Interesting and memorable spots that normalized FP use through everyday slice-of-life situations with emotional appeal.
- Key roles for influencers
  - The husband and mother-in-law in larger roles
    - Presenting mothers-in-law, who have significant influence over FP decision-making, as role models.
  - ASHAs, as the link between families and the health service system, in a mentoring capacity.

Interventions and Activities, and Duration:

Campaign tag line

A tag line was developed, pre-tested and finalized for use as a common thread in all spots.

Phase I (July – December 2009)

Re-launching of all previously developed FP spots including 12 TV and 3 radio spots from USAID and UNICEF focusing on birth spacing, ANC, breastfeeding and newborn care.

The Tag Line

'Pati patni karen vichar, swasth naari, swasth parivar'

'When a husband and wife interact, it results in the better health of woman and the family.'

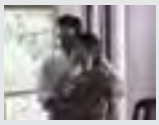
Implied Meaning: When a couple has open communication, they can use their knowledge to plan their family.

TABLE 5: KEY MESSAGE AND AUDIENCE FOR FP MASS MEDIA CAMPAIGN

Message	Audience
Audience	
• **Primary:** Intended audiences varied with the particular communication theme:	
Delaying the first birth	Newly married couples
Three years' spacing between children	Couples with at least one child
Postpartum use of IUDs	Couples who just delivered, or are about to deliver their child
Postpartum use – any contraceptive	Couples who have completed their families
Postpartum male sterilization	Couples who have completed their families, particularly men
Postabortion contraception	Couples where the woman has undergone an abortion
• **Secondary:** Family elders	

Phase II (January – March 2009)

TABLE 6: TV SPOTS/ RADIO SPOTS DEVELOPED AND AIRED DURING FP MASS MEDIA CAMPAIGN (PHASE II)

	PHASE II Message/Topic	Mass Media Spots	Creative Approach
	Delay age of marriage	1 TV spot 1 radio spot	*Mard ki daad* (The Mark of a Man) – A group of men discuss their 'manly' deeds when one says he stood against his relatives who were forcing his under-age daughter to marry early.
	Basket of contraceptives	1 TV spot 1 radio spot	Animated video with a catchy song and modern visuals shares a range of contraceptives and their benefits.
	Delay first child	1 TV spot 1 radio pot	*Aisi bhi kya jaldi hai* ("What's the Big Hurry!") – A newly married couple asks relatives who are pressuring them to have a baby, "What's the big hurry?"
	Use of contraception after abortion	1 TV spot	*Nayi subah* ("A New Dawn") – A couple who recently had an abortion realizes they should have adopted a FP method to avoid the abortion, and ultimately chose to use an IUD to space their children.

Phase III (June – September 2010)

TABLE 7: TV SPOTS/ RADIO SPOTS DEVELOPED AND AIRED DURING FP MASS MEDIA CAMPAIGN (PHASE III)

	PHASE III Message/Topic	**Mass Media Spots**	**Creative Approach**
	Three years' spacing between children	1 TV spot 1 radio spot	*Sahi Waqt Pe* ("At the right time") – Two men discuss everyday things that happen at the right time, such as the planting of seeds, and realize that the right time to have a child is three years from the last born.
	Postpartum contraception	1 TV spot 1 radio spot	*Taiyaari Hamesh Pehle* ("Be prepared") – A husband tells his friend that it is better to plan and be prepared for things in life, and he and his wife have adopted PP contraception to plan their family.
	Postpartum IUD	1 TV spot	Fix It – An enthusiastic husband who fixes all his family's problems finds answers to spacing from an ASHA.
	Increased male sterilization	1 TV spot	*Mujh Pe Chhod Do* ("I will handle it") – A husband who likes to handle his family's affairs decides to go for sterilization for the sake of their well-being.

Results: This mass media campaign has been aired by the MoHFW twice between 2010 and 2011.

PROMOTION OF THE JSK HELPLINE

The **"Jansankhya Sthirata Kosh"** (JSK) (National Population Stabilization Fund) has been established to promote and undertake activities aimed at achieving population stabilization at a level consistent with the needs of sustainable economic growth, social development and environment protection, by 2045. JSK is a unique organization. Its goal is to promote initiatives that leverage the strength of different economic and social sectors and reach out to needy population groups through innovative strategies. It is a combination of government and civil society working hand-in-hand to promote innovations by drawing on the strength of joint partnerships.

JSK has established a helpline service to give information on RH, FP and CH issues in English and Hindi using an automated computer based software that has multiple questions and answers to respond to the callers' queries based on taxonomy for common questions. It is intended to fill the information gap on contraception, safe abortion, pregnancy, sexually transmitted diseases, infant and child health issues among teenage mothers or unmarried and newly married couples. Technical support has been provided by National Informatics Center (NIC), NASSCOM and the Central Bureau of Health Intelligence (CBHI). The software was prepared by the Department of Community Health of Maulana Azad Medical College. The call center receives an average of 300 calls per day. Based on June 2008 to June 2010 data, trends indicate that the percent of male callers are higher than the female callers; approximately 70 percent of the callers were married, and a majority of the callers were from the age group of 21–30.

JSK sought assistance from the USAID funded IFPS project to develop two TV and radio commercials to promote the helpline as a credible source of information on FP and sexual health.

Strategic Approach and Objectives: The objective of this campaign was to increase knowledge about the Helpline and the services it provided as well as to motivate audiences to call the helpline for information on relevant health topics, where to seek additional information (from local sources), and other issues.

Audience: It was strategically important to target soon-to-be married couples and newly married couples to shape positive attitudes and support the adoption of recommended behaviors that would persist. As this age group was also technology and mobile phone friendly, the creative approach took advantage of alternative media channels.

Creative Approach: Popular Hindi cinema and topics from popular culture were used in a fun, empathetic and endearing manner to motivate young couples to ask questions relating to FP and sexual health, clichés related to love, marriage and sex. In the first film, it was shown that Indian lovers are inspired by movies and go to lengths to woo one another, taking cues from film. However, as Hindi films do not inform the audience of what happens after love, they are advised to call the helpline for credible information. In the second film, actors in the 'REEL' world ask difficult questions to make an example that in REAL life there are difficult questions related to FP and sexual health from which we shy away. Thus, the helpline provides credible information.

Interventions and Activities, and Duration

Campaign tag line

"*Poocho to Jano*" ("Ask and Know"), was the campaign tagline that addressed both the mothers and daughters, and under which two commercials were developed. The two TV and radio spots were aired nationwide by JSK February 2012 onwards on all public broadcast and CNS channels and even displayed at events and fairs that are regularly organized by JSK, and invested around 1.75 crore on television alone.

Results: Since this campaign is being implemented as this document is being developed, no impact study has been conducted.

MENSTRUAL HYGIENE CAMPAIGN

In India, menstruation and menstrual practices are clouded by taboos and sociocultural restrictions for women and adolescent girls. Limited access to products for sanitary technology and lack of safe sanitary facilities could be barriers to increased mobility and the likelihood of resorting to unhygienic practices to manage menstruation. Traditionally in India, it appears that there are three primary strategies for sanitation during menstruation: use of old clothes as pads by recycling them, no protection, or making disposable pads with material available at home.

Anecdotal evidence suggests that the lack of access to menstrual hygiene (which includes availability of sanitary napkins, toilets in schools, availability of water, privacy and safe disposal) could constrain school attendance and possibly contribute to local infections during this period. Therefore, creating awareness and increasing access to the requisite sanitary infrastructure related to menstrual hygiene is important. The GoI's commitment to adolescent reproductive and sexual health (ARSH) in RCH II recognizes the importance of influencing the health seeking behavior of adolescents.

Social Marketing of Freedays Sanitary Napkins:
In 2010, the MoHFW launched their own brand of sanitary napkins named Freedays, priced at Rs. 6/- for six napkins. In the first phase, the napkins were to be marketed by the ASHA and the scheme was to be rolled out in 150 districts across the country.

The IFPS project was requested to develop two TVCs and two radio spots to help adolescents understand that menstruation is normal, hygiene is very critical, and that sanitary napkins are a hygienic way to managing periods. The first commercial was for 10–14 year olds and the second was for older girls. Formative research helped address the key barriers to positive behaviors and triggers for communication. The commercials were pre-tested and findings were incorporated in the final campaign.

Strategic Approach and Objectives: Through empowerment from using role models, promoting behaviors and benefits, and addressing barriers, audiences are motivated to improve attitudes towards and to adopt positive behaviors related to menstrual hygiene by use of sanitary napkins.

Audience: Adolescent girls aged 10–14 and 15–19 years, and mothers of adolescent girls.

Creative Approach: The creative approach to this campaign was to use positive role models and normalize the key behaviors. The mother–daughter relationship was used to show positive mothers who prepare their daughters for menarche, talk to them about menstruation, provide sanitary napkins and are good role models. The approach was based on the findings from secondary research provided by MoHFW that:

- The onset of menarche among 10–14 year old rural girls is traumatic, psychologically disturbing, socially embarrassing and alienating. This is intensified given that mothers do not prepare their daughters for menarche or suggest using sanitary napkins.
- Confusion, taboos and unexplained restrictions surround young girls.
- There is little information or knowledge among both mothers

and daughters since discussing menstruation is stigmatized.

- Lack of information and knowledge perpetuates ill-informed superstitions and beliefs.
- Unhygenic practices including use of sanitary napkins made from old clothes which are washed and frequently reused or the lack of sanitary products, left young girls vulnerable to infections and disease.
- Lack of availability and affordability of sanitary napkins leads to perpetuation of these unhealthy practices.
- Restrictions on freedom of movement and activity have created a barrier that has led to rampant school absenteeism.

Thus, the campaign developed two core messages:

- **Empowerment through knowledge:** Develop confidence to understand and accept menarche as natural and to view it positively as a "change that happens to every girl" and that "she is not alone".
- **Empowerment through protection:** Increase comfort and hygiene through greater access to sanitary napkins, which are now available at BPL/APL prices for these girls.

Interventions and Activities, and Duration

Campaign tag line

"*Taiyaar Raho, Taiyaar Karo*" (Prepare and Be Prepared) was the campaign tagline addressed to both the mothers and daughters.

The two TV and radio spots were aired nationwide by MoHFW from November 2011 onwards on all public broadcast and CNS channels.

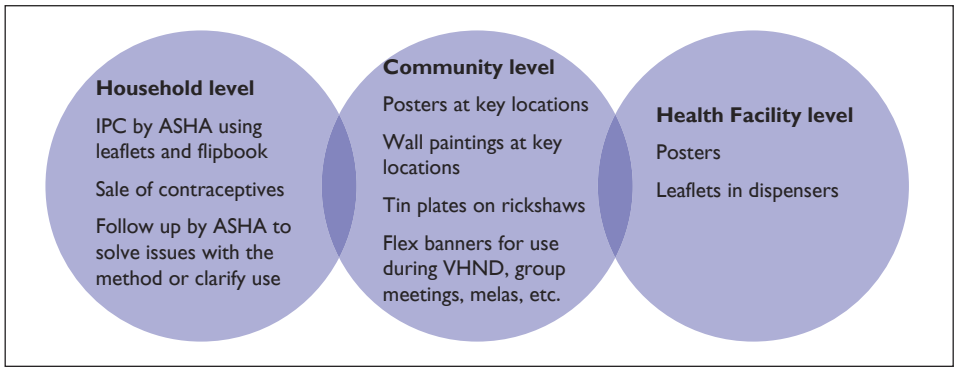
Results: Since this campaign is being implemented as this document is being developed, no impact study has yet been conducted.

CAMPAIGN TO PROMOTE SOCIALLY MARKETED CONTRACEPTIVES BY ASHA

Until now, the MoHFW, GoI had been providing free distribution of oral contraceptive pills, condoms and emergency contraceptive pills to all beneficiaries under the NRHM. However, access to these contraceptives is reported to be low because of delays in making supplies that are available at the sub-district level and downwards, among other causes. As such, use of contraceptives in the country has been largely static. Further, unmet need for spacing methods continues to be substantial.

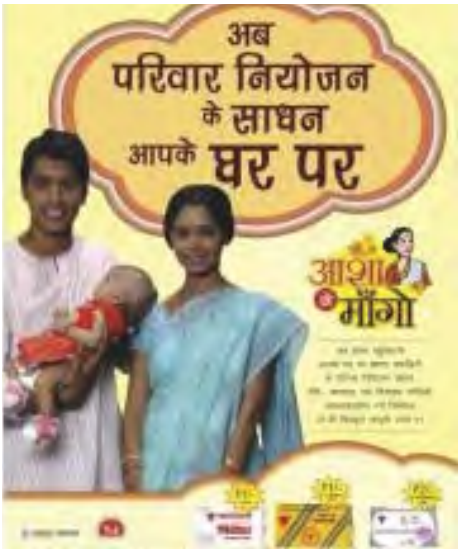
To improve access to contraceptives for eligible couples, a pilot project has been developed to utilize the services of the ASHA to deliver contraceptives at the doorstep of households and incentivize her for this effort. The initiative is being implemented on a pilot basis in 233 districts in 17 states. In the districts where the distribution of contraceptives through the ASHA is being introduced, the free supply of contraceptives at primary health center (PHC) and sub-center levels stands withdrawn in the light of the new provision of home delivery of contraceptives by the ASHA. However, free supply of contraceptives at community health centers (CHCs), sub-divisional and district level hospitals shall continue as before. In the districts and states that are not covered under the pilot, the existing system of the free supply of contraceptives at all centers shall similarly continue. The IFPS project was requested by the FP division of the MoHFW to design a community level campaign for the same.

FIGURE 1: STRATEGIC BCC APPROACH



Strategic Approach and Objectives: The objectives of the campaign were:

- to inform clients that contraceptives delivered by the ASHA will be charged nominally and that the facility based ones will be free of cost; and
- to help audiences identify the differences in the packaging of the contraceptives between those that will be charged and those for free distribution.



Audience: Men and women of reproductive age.

The IFPS project designed a communication strategy that included a mix of activities that reached beneficiaries at the family/ household level, community level and health facility level. A set of posters and banners were designed that focused on branding of these products, wherein clear differentiation between free and ASHA marketed contraceptives was made. A mnemonic was designed for the audience to recognize the ASHA and the contraceptives she provided under the socially marketed route.

Interventions and Activities, and Duration: The campaign was launched in January 2012 in the EAG states.

Campaign tag line: *ASHA se mango ("Ask/Demand from the ASHA")*

Results: This campaign was launched by the MoHFW in January 2012, thus no assessment has yet been conducted.

MULTIMEDIA IUCD CAMPAIGN

The MoHFW decided to increase uptake of intrauterine contraceptive device (IUCD) by introducing IUCD 375 as an alternate short-term option and requested the IFPS project to design a mass media campaign with some promotional collaterals that could be used in the EAG states. The IFPS project suggested the use of the existing Suvidha IUCD campaign that it had developed in the past for UP, but was never aired due to branding issues. The Suvidha campaign was still applicable. Thus, the MoHFW agreed to use the same campaign with minor revisions.

Strategic Approach and Objectives

- Generate demand for IUCD by:
  - positioning IUCD as a trouble free, reliable, clinic-based method of contraception providing protection from unwanted pregnancy, spacing between pregnancies and long acting temporary methods for limiting pregnancies;
  - introducing IUCD 375 as an alternate short-term option; and
  - addressing the prevalent myths and misconceptions.

Audience

- **Primary Audience:**
  - Women 25–45 years with one or more children wanting to either space or limit family size
- **Key Influencers:**
  - Husbands
  - Mothers-in-Law
  - Service Providers

Interventions and Activities

- Communication Activities:
  - Mass Media
    - Television commercials
    - Radio commercials
  - Local and mid-media:
    - Posters, banners and tin plates
    - Wall paintings and hoardings
  - Health Facility level media:
    - Posters on myths

Creative Approach: The creative approach was to promote IUCD as trouble free and reliable FP method. It showcased key influencers that highlighted benefits and endorsed this product as a viable FP method.

Duration: The government will launch this campaign in April 2012.

ATMAJAA TV SERIAL DRAMA

The *Atmajaa — Born from the Soul* serial drama was developed and aired nationally on Doordarshan (the public broadcaster). It addressed female feticide and the dignity of girl children, and explored stigma associated with gender discrimination. Many activities to increase awareness on these issues were carried out between 2001 and 2003. One of the activities includes airing of a short film, titled *Atmajaa*, on national and regional television and in schools.

The impact of these activities and the short film was used to develop a pilot TV series, *Atmajaa*. This was produced and aired in 2004. The MoHFW considered this initiative as effective in introducing health and gender issues to audiences in an entertaining and informative way and recommended that additional episodes be produced and aired to reinforce and expand upon the topics from the pilot series.

Strategic Approach and Objectives: Using the EE approach that allows audiences to have an ongoing relationship with compelling characters and storylines, introduce the issue of female feticide and other gender issues, and positively influence related knowledge, attitudes and behaviors.

The Creative Approach

Create characters that audience members can easily identify with and view as role models, and introduce themes and messages through the characters as they tell their stories in scenes from everyday life.

Audience: Youth, married couples and in-laws.

Duration:
13-episode series in 2004
52-episode series in 2005–06

Interventions and Activities
Phase I (pilot): 13 episodes

- Presented issues of female feticide, gender inequality, and health and social well being of girls.

TABLE 8: PRODUCTION MILESTONES FOR ATMAJAA TV SERIAL DRAMA

2004	Production of the 13-episode pilot *Atmajaa*	Produced by Plan International, and aired by MoHFW nationally, regionally, and internationally. Reports on female feticide gained global attention.
2004–05	Pilot series evaluation	The pilot had high television rating points among audiences, and insights for production of a new series were gained.
2004–05	Plan developed for a 52-episode series	MoHFW approved the plan and production began.
2005–06	Production of first 26 episodes	Aired nationally on Doordarshan and regional channels. Print and electronic media report on the series, increasing awareness of the drama and the issues.
2006	Production of final 26 episodes	MoHFW approved production and airing of the additional episodes.

Phase II: Episodes 1–26 of 52-episode series

- Connected viewers with characters as role models, introduced during the pilot series.
- Elaborated on issues presented during the pilot and explored underlying factors in depth.
  - Themes included gender inequality, dowry, rape, female infanticide, women's rights, reproductive rights, property rights, domestic abuse, trafficking of women, sex selection and sex selective abortion, sexual harassment and the law.

Phase III: Episodes 17–52 of 52-episode series

- Part I (13 episodes) presented contemporary issues delving into mainstream health and family welfare problems at family and societal levels.
  - Focused on medical ethics, youth and adolescence, caring for elders, sexual harassment in the workplace, domestic violence, gender inequality, mother-in-law and daughter-in-law relationships, child sexual abuse and sexual abuse laws, female feticide, property rights, women's rights, sex selective abortion, and forced polyandry or bride selling.
- Part II (closing 13 episodes)
  - Targeted youth and focused on adolescent health, early marriage/age at marriage, maternal health, institutional delivery, FP including birth spacing, government health schemes, and career and development opportunities.

CAPACITY BUILDING

NATIONAL IEC WORKSHOP

The mid-term review of RCH-II in 2009 completed by GoI and development partners identified a need to sensitize and build capacity for health communication among IEC officials to strengthen programs and interventions. Recommendations from the review included regular meetings to share best practices among states, and capacity building for key principles of BCC. To help the NRHM meet its long-term goals and objectives, the IFPS project organized a national IEC workshop for MoHFW on RCH to enable better coordination and exchange of ideas between officials across government sectors.

Strategic Approach and Objectives: To build capacities of IEC staff at the state level in designing strategic BCC programs through:

- Renewed dialogue between states and the national IEC department to share and learn from experiences of innovations and successful BCC campaigns
- Development of a more focused BCC activity plan for the following year's state Program Implementation Plans (PIPs)
- Understanding issues and challenges faced by state IEC officials in planning, implementing and monitoring BCC activities.

Audience: State level IEC officers from across India, communication specialists from development partners, and IEC officials from MOFW.

TABLE 9: NATIONAL IEC WORKSHOP AGENDA

TOPIC	SPEAKER
Developing BCC strategies using the UP strategy and as e.g. new strategies, new media and new approaches.	Ms. Geetali Trivedi-BCC Advisor, JHUCCP, ITAP Project, India
Challenges in implementation of BCC programs	Mr. Ram Mohan Rao, Former Principal Information Officer, GoI
Developing the right message for the right audience	Prof. Devki Nandan, Director, NIHFW
Priority behaviors for health under:	
Family planning	Dr. SK Sikdar, Assistant Commissioner, Family Planning Division, GoI
Child health and	Dr. Manisha Malhotra, Maternal Health Program, RCH II/NRHM, MoHFW
Maternal health	B. Kishore, Assistant Commissioner, CH, MoHFW
H1N1-The emergency response	Dr. AC. Dhariwal: Additional Director, Public Health and National Project Officer, National Center for Disease Control
Media Planning	Ms. Mattu JP Singh, Director, DAVP, GoI
Anti Tobacco and Mental Health	Dr. Jagdish Kaur, Chief Medical Officer, Directorate General of Health Services, MoHFW
Field Publicity-Using mid media effectively	Ranjana Dev Sarmah: Director, Directorate of Field Publicity, Ministry of Information & Broadcasting
BCC for Adolescent Health	Geetanjali Agrawal, Consultant, ARSH
State presentations: efforts in BCC and innovative communication strategies	18 State IEC Officers
Group work: Developing Annual Media Plans	Facilitator: Sheena Chhabra, Chief of the Health Systems Division of the Office of Population, Health and Nutrition (PHN) at USAID
	Participants: Andhra Pradesh, Arunachal Pradesh, Bihar, Gujarat, Haryana, Madhya Pradesh, West Bengal
Group work: Importance of interpersonal Communication	Facilitator: Supriya Mukherjee, Program Communication Specialist, UNICEF
	Participants: J&K, Kerala, Punjab, Rajasthan, Nagaland, Chhattishgarh, Chandigarh
Group work: Innovative Media Options	Facilitator: Rajat Ray, Senior Advocacy and Communication Officer, UNFPA
	Participants: Tamil Nadu, Tripura, Uttar Pradesh, Maharastra, Delhi, Himachal Pradesh

Interventions and Activities

- Workshop agenda developed to address BCC for priority RCH areas.
- Special sessions facilitated by program heads of MH, CH and FP, and various government media departments including the Directorate of Visual Publicity.
- Participatory sessions on Annual Media Planning, IPC interventions and Innovative Media Options.

Duration: August 20–21, 2009.

Results

- Representatives from 22 states attended, with 18 states sharing innovative IEC/BCC approaches and methods.
- Recommendation for more platforms similar to the workshop for discussion and mutual learning:
  - Development by states of their PIPs with inclusion of BCC activities
    - Uttar Pradesh adopted this model for the 2010–11 PIP.

TABLE 10: HEALTH INNOVATIONS SHARED AT THE NATIONAL IEC WORKSHOP

Andhra Pradesh	Assam	Bihar	Chandigarh
• Printing IEC messages on NRHM and family welfare on school notebooks and savings booklets used by the postal department • 108 Ambulance Services • Fixed Health Day Services • 104 Health Information Helpline • Running scrolls on television screens for 100 days on key messages of all interventions of NRHM and special family welfare activities on occasions such as Diwali, X-Mas, New Year's eve	• Counseling and advocacy programs in schools on ARSH and sanitation • Radio jingles in 11 different dialects developed and broadcast • Video shows for people in the rural areas with no access to low-cost entertainment • Tableau through the city carrying health messages under IEC activities	• A Health Action Plan on IEC for each district addressing diversity, e.g. drought/flood prone districts along with differential funds based on cultural and geographical challenges • Milk collecting units from different villages (COMPFED) reach messages to inaccessible areas of the state. • Using festive occasions to create low-cost, high-impact messaging. E.g. messaging on Rakhi envelopes.	• Traffic roundabouts were used as a "Health Chowk" to display different IEC messages, concepts and designs • New health messages, each month on displayed Bus shelters • Using a tourist vehicle – Chandigarh's Hop On Hop Off bus with health messaging interspersed creatively within promotional literature on tourism • Simple messaging on utility vehicles like milk vans • Active school health scheme that has regularly updated capsules on diet and nutrition, tuberculosis, tobacco awareness, etc.

NRHM ADVOCACY FILM

Based on the request from MoHFW, a 10–12 minute multimedia advocacy film was developed in 2007 to showcase the initiatives, activities and achievements of the NRHM and outline their tasks heading up to 2012. The film was produced in English and Hindi for use at international forums and for key stakeholders.

Strategic Approach and Objectives: Increase awareness and recognition, and generate demand for the NRHM's services:

- Present the concept of the NRHM, its vision and objectives, the framework for the mission, the branding of health programs, specific interventions such as the ASHA, Janani Suraksha Yojana (JSY), Rogi Kalyan Samities (RKS), and Indian Public Health Standards (IPHS).
- Share innovations and best practices across states such as the boat clinics of Assam that deliver health services to families along India's northern rivers, IPC/C interventions of Orissa and the intercommunication initiative of Jharkhand.
- Capture comments and testimonials from functionaries of the MoHFW, GoI through state and field level interviews, especially with ASHAs, and share the participatory approach of beneficiaries.

Audience: Key stakeholders at healthcare facilities and community level NGOs.

Duration: Produced in 2007

LESSONS LEARNED AND PROMISING APPROACHES

Through the mass media campaigns and assessments, and TV serial drama employing an EE approach, the following key lessons were learned:

- The use of celebrities to promote BCC related to FP and RCH may not necessarily be more effective than employing other more traditional approaches such as the use of cultural symbols or traditions.
- Language and phrasing of messages, if not simplified for intended audience, may lead to low levels of recall and comprehension.
- Messages must be culturally and socially appropriate for the intended audience, and improved through pre-testing.

The mass media campaigns and TV serial drama highlighted best practices for effective message recall and comprehension, and positive changes in knowledge, attitudes and behaviors.

- Reinforcement and expansion of messages over time and through various channels such as mass media and IPC improves recall and comprehension.
  - The importance of IPC was demonstrated through improved recall and comprehension of messages when aided or prompted.
- Creative and entertaining approaches to BCC, including the use of EE, effectively capture audiences' interest and attention, encourage social dialogue, and lead to positive changes in knowledge, attitudes and behaviors.
- A collaborative approach to developing capacity building and advocacy strategies with key stakeholders across multiple levels of the health system can lead to the integration of more effective BCC into existing programs.

What Works

- Creative, memorable and entertaining BCC.
- Simple, culturally appropriate messages that use clichés from daily life.
- FP messages that address the men and provide benefits , especially economic benefits, both short and long-term.
- Demonstrating vital role of men in health and family planning while designing FP messages.
- FP 30 and 60 second TVCs that have one catch phrase repeated in different situations instead of storylines.
- Reinforcement and expansion of messages over time
- Capacity building and advocacy strategies developed collaboratively with key stakeholders.

SECTION 2

Behavior Change Communication

Uttar Pradesh

The Power of Innovations and Partnership

"सखीली स्वस्थ किशोरी योजना"

BEHAVIOR CHANGE COMMUNICATION

NRHM BEHAVIOR CHANGE COMMUNICATION STRATEGY

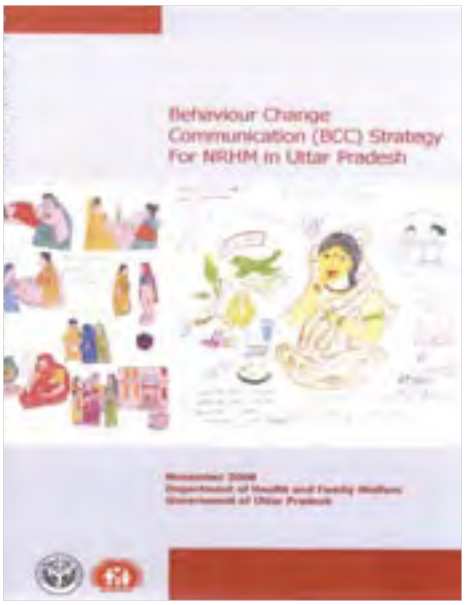
Development of the NRHM's BCC Strategy for UP

Uttar Pradesh is one of the first states in India to initiate a state level BCC strategy for the NRHM. The BCC strategy was developed to provide a blueprint for focused interventions to achieve the NRHM goals. The strategy is evidence-based, and utilizes a major ancient Indian theory of communication known as *Sadharanikaran,* in addition to the Pathways model™ from JHUCCP. The model focuses on 14 priority behaviors for BCC through a multi-pronged communication approach including IPC and community events/ activities, community mobilization and mass media.

Strategic Approach and Objectives: Improve health service delivery and outcomes through the development, orientation and delivery of a plan for strategic BCC, addressing priority behaviors across 14 key health issues within all districts and across all levels of program delivery in UP.

- Address gaps in BCC strategy and capacity in the state:
  - Propose activities to close gaps in coordinated BCC efforts across and within national and regional programs.
  - Build capacity of healthcare program managers and frontline workers for integration with state mass media activities, and decentralization of BCC activity planning at the district, block and village levels.

Audience: All stakeholders at all levels working in UP under various health programs.



Interventions and Activities

- Develop and deliver a BCC strategy for the NRHM in UP that identifies priorities for improving health across populations through integration and coordination of activities, and adaptability at district, block and village levels. The document is divided into key sections:
  - Situation analysis of health in UP
  - Selection of priority behaviors and barriers analysis
  - Overarching BCC strategy for interventions and innovations
  - Plans for short-term BCC interventions
  - Plans for long-term BCC interventions
    - State level roles and responsibilities
    - District level roles and responsibilities

- BCC guidelines for implementation
- Building BCC capacity among health program managers
- Supportive supervision, monitoring and evaluation
- Recommendations and conclusions

- Develop and deliver a guide for implementing BCC activities outlined in the state strategy at the district, block and village levels through program health managers and frontline workers.
- Design a model for orientation, training and capacity building of district, block and village level functionaries to integrate BCC activities from the state strategy with annual PIP.
  - Inclusion of a cascade training component for master trainers to build capacity for BCC activity integration with PIP in all districts of UP.
- Delivery of a training-of-trainers (TOT) capacity building workshop for key district and block level functionaries to train master trainers for cascade trainings throughout UP.

Duration: November 2008 onwards.

Results:

- The *BCC Strategy for NRHM in Uttar Pradesh* was delivered to the Government of UP, and has been adopted at the state level.
- A model for capacity building TOT and subsequent cascade trainings was developed and delivered to the Government of UP, and has been deployed at the district and block levels.
- The capacity building TOT program was delivered and included two participants from each district: District Community Mobilizers (DCMs) and District Health Education and Information Officers (DHEIOs/Deputy DHEIOs) for a total of 33 districts and 69 participants (in Allahabad regional workshop) and 38 districts and 73 participants (in Agra regional workshop). Overall, 71 districts in UP were covered and 142 participants oriented through the "*Soch se Amal tak!*" workshops.

NRHM'S BCC IMPLEMENTATION GUIDE FOR UP

FROM AWARENESS TO ACTION – A GUIDE FOR DISTRICT AND BLOCK LEVEL FUNCTIONARIES TO IMPLEMENT BEHAVIOR CHANGE COMMUNICATION PROGRAMS

A guide was developed for district and block level health program managers to simplify implementation of the BCC activities outlined in the state's strategy.

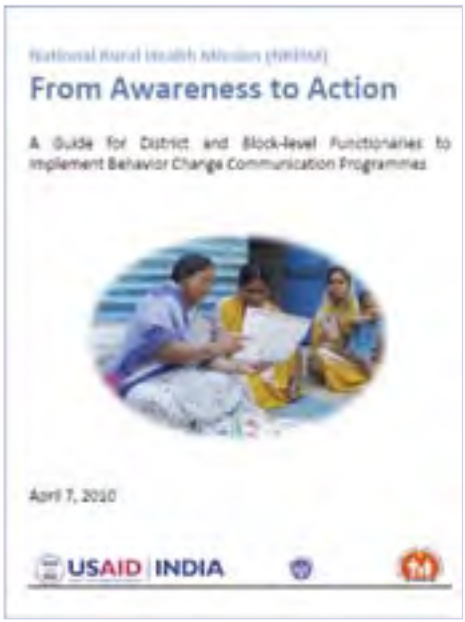
Strategic Approach and Objectives: Provide a hands-on guide to district and block level managers responsible for implementing BCC activities in their communities through an abridged version of the strategy document that would:

- provide clear guidance and direction on how to mobilize, implement and monitor activities in the field; and
- provide supporting and monitoring tools for implementation in the field.

Audience: BCC functionaries at district and block levels: DCM, DHEOs, HEOs and BPMs.

Duration: January 2010 onwards.

Results: The guide was distributed to district and block level functionaries at capacity building workshops in Allahabad and Agra, and will be distributed to other districts through capacity building workshops to ensure widespread coverage and use.



CAPACITY BUILDING

DEVELOPMENT OF THE ASHA NEWSLETTER

Under the NRHM, ASHAs have been selected from their village to create awareness on priority health issues, to promote and mobilize better healthcare planning and healthcare seeking practices, and increase utilization and accountability of existing healthcare services. Capacity building for ASHAs is seen as a continuous process going beyond initial training in order to ensure they are equipped with accurate and timely information, and well-honed skills.

Communication for, about, and between ASHAs was deemed important to continue the capacity building process, and to further enhance ASHAs' knowledge and skills to deliver BCC. Over 130,000 ASHAs work in UP and present a significant opportunity to disseminate effective messages for priority health behaviors if they are continually trained, informed, motivated and empowered. A 12-page newsletter, known as *Ashayein*, was created to take advantage of this important communication channel.

Strategic Approach and Objectives

- Build capacity of ASHAs continually by increasing the use and dissemination of regular, accurate and up-to-date information to improve health service delivery and outcomes in UP.
- Create a forum for bringing together ASHAs, position the role as a skilled deliverer of quality and timely healthcare information within the community, and recognize ASHAs as an identity.
- Provide solutions to issues faced by ASHAs to enhance their counseling skills.
- Serve as a motivational tool by recognizing evidence-based work of ASHAs, encouraging them to share their stories and experiences, and act as a source of inspiration to others.

Audience: ASHAs working in UP.

Interventions and Activities

- Completion of an informal needs assessment through field visits with ASHAs.
- Formation of a core group of subject matter specialists from the Government of UP, SIFPSA, and IFPS project.
- Development of a conceptual framework for a newsletter through a participatory process, pre-tested with ASHAs through individual interviews and focus groups for comprehension, retention, appeal, likeability, overall impact and intention to respond.
- Production and printing of the *Ashayein* newsletter.
- Development of a distribution system for the newsletter through Chief Medical Officers (CMOs) in each district who then distribute it to ASHAs.

Duration: Quarterly, beginning with the July–September 2008 issue.

Results

- A qualitative assessment of ASHAs carried out in Sitapur and Barabanki revealed that *Ashayein* had high likeability, comprehension and usefulness among ASHAs and they relied on *Ashayein* for sharing information with their communities.
- Issues of the *Ashayein* Newsletter were developed up to June 2011 and 150,000 copies of each issue were printed for more than 137,000 ASHAs working in the state.

DISTANCE LEARNING PROGRAM

While frontline health workers in UP are trained in technical skills, they displayed low self-image, and perceived lack of appreciation for their role in the communities they work in. The need was thus to create a campaign that highlighted their role as a link between the community and the health services, as a credible and trained health promoter and provider of consumables like oral rehydration solution (ORS), oral contraceptive pills (OCPs), condoms, etc. Radio presented an opportunity to increase knowledge and improve skills critical to the effective dissemination of BCC messages by local healthcare providers.

Strategic Approach and Objectives: Through the reach of radio, improve knowledge and skills of frontline healthcare providers such as ASHAs and ANMs:

- Increase knowledge about health issues including FP, reproductive tract infection (RTI), sexually transmitted infection (STI), HIV/AIDS, MH, CH, and age at marriage.
- Build IPC skills by demonstrating enhanced client–provider interactions through representative characters and radio role plays.
- Motivate and empower frontline health providers by instilling in them a sense of pride and self-respect.

Key Messages

- ASHAs and ANMs are valuable to the community, and contribute to the health and well-being of families.
- They should be proud of their work. Continual learning will instill pride and confidence.

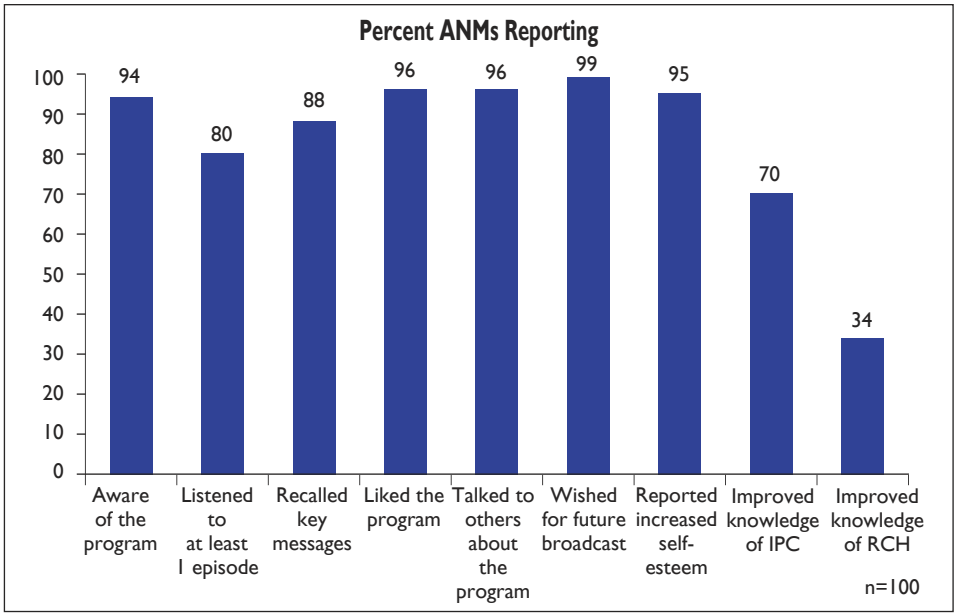
Audience: ASHAs and ANMs.

Interventions and Activities

- Development and airing of a 26-episode radio educational program addressing health issues, myths, misconceptions and good healthcare seeking behaviors.
  - Episodes talk of FP and contraception issues, maternal and child health, and effective IEC and IPC skills.

Results: Through a qualitative assessment of ANMs in five blocks of Jhansi district, the radio distance learning program was found to have high levels of listenership, comprehension and appeal, and increased knowledge specifically in IPC and RCH.

FIGURE 2: IMPACT OF THE DISTANCE LEARNING PROGRAM ON ANMS



RADIO DRAMA SERIES

RADIO DRAMA SERIES

Radio is an important component of mass media with a wide reach across rural UP, thus offering a unique media edge most importantly among rural audiences, the largest and most critical audience for the IFPS project communication effort. In fact, more women and men in UP are exposed to radio than in India overall (NFHS-3).

UP has high maternal mortality, lack of institutional delivery, and high rates of RTIs and STIs. There is also a large gap between awareness (95 percent) and use (27 percent) of modern methods of contraception (NFHS-3). One of the major reasons for low and inconsistent use of contraception is misconception about contraceptive methods and cultural taboos on the subject. Thus, a radio drama series was used to disseminate BCC messages to the general population addressing these myths through factual information and perspectives of users.

Strategic Approach and Objectives: Using an EE approach, through representative and compelling characters and storylines:

- Increase knowledge and dispel myths and misconceptions about health issues including FP, RTI, STI, HIV/AIDS, MH, CH, and age at marriage.
- Present role model couples discussing FP.

Key Messages

- Women and men alike have the right to good health.
- A happy family is a small, healthy and planned family.
- A planned family improves health, education and quality of life.
- Couples should plan their family size and health together with the help of a healthcare provider when needed.

- Motivate and empower responsibility and action for healthcare.

Audience:

- Rural men and women of reproductive age and their families.
- Local community leaders.

Interventions and Activities: Development and airing of a 26-episode radio drama series addressing health issues, myths and misconceptions, and good healthcare seeking behaviors.

- Episodes address the well-planned family, value of a girl child, importance of delayed marriage, male involvement in decision-making, and male involvement in caring for women and children.

Duration: 2004–07; 2008.

Results

- Demand for the first radio drama series was high, and led to the development and airing of a second 26-episode radio drama — *Sunehere Sapne Sanwarti Rahein* (2008) – expanding upon messages of the original series.
  - Issues addressed included the role and contribution of ASHAs and ANMs to the health and well-being of communities, nutrition, hygiene, immunization, gender issues and population stabilization.
  - Aimed to create awareness and generate demand for JSY.
- A mid-term evaluation revealed high popularity and positive feedback on the series, a desire of listeners for a TV series based on the topics covered in the radio drama, and message dissemination through multiple channels including print and electronic media.

MULTIMEDIA FEMALE STERILIZATION CAMPAIGN

The XXXVIII PAC held in January 2004 recommended the promotion of female sterilization through a multi-media communication campaign to increase uptake. The project envisioned development and implementation of a BCC campaign aimed at positively impacting attitudes towards female sterilization and increasing the number of women adopting sterilization. Accordingly, a BCC package was developed for UP.

Strategic Approach and Objectives: Through a coordinated multi-channel communication approach:

- Increase knowledge of female sterilization.
- Improve attitudes and motivate behaviors for female sterilization.

Audience

- Couples 25 years and older with an unmet need for sterilization and their families.
- Influential community leaders.
- Healthcare service providers.

Interventions and Activities

- Develop and pre-test a package of BCC campaigns through a wide range of channels including radio, TV, folk performances, wall paintings, hoardings/ billboards, posters and cinema slides.
- Deliver the mass media campaign across the state, and local media campaign in 33 focus districts.
- Creative package includes:
  - TV Films – Two films in Hindi:
    - Camp film (60 sec and 30 sec)
    - Teej film (40 sec and 30 sec)
  - Radio Spots – Five separate spots in Hindi:
    - Camp spot (60 sec)
    - Teej spot (40 Sec)
    - ANM Behanji spot (60 sec)
    - Saas Bahu spot (60 Sec)
    - RCH Camps spot (60 Sec)
  - Poster – Bilingual Poster
  - Wall paintings:
    - Doctor visual theme
    - 'Woman with Pot' visual theme
  - Hoardings:
    - Doctor visual theme
  - Cinema slides

Key Messages

- Promote usefulness and ease of female sterilization.
- Address post-operative complication.
- Promote sources of services.

Duration: First Round – May to August 2006; Second Round – June to September 2007.

Results

- In the first round of the campaign, 25 TV spots and 2,304 radio spots were aired; 43,150 posters were printed and distributed; 411 hoardings and 66 glow signs were installed across 33 IFPS project-focal districts; and 1,126 folk performances were organized in 33 IFPS project-focal districts.
- During the second round (mass media focused), 647 TV spots and 2,146 radio spots were aired, in addition to the release of 260 newspaper ads in a number of leading regional dailies.

MULTIMEDIA IUCD CAMPAIGN

SUVIDHA IUCD CAMPAIGN

Strategic Approach and Objectives:

- Generate demand for intrauterine IUCD by:
  - addressing the prevalent myths and misconceptions;
  - creating brand positioning and a visual identity for the newly launched Copper-T (CuT 380 A); and
  - positioning CuT 380A as a trouble free, reliable, clinic-based method of contraception providing protection from unwanted pregnancy for up to 10 years.
- Upgrade the counseling and IPC skills of service providers.

Audience:

- **Primary Audience:**
  - Women 25–45 years having one or more children wanting to either space or limit family size.
- **Key Influencers:**
  - Husbands
  - Mothers-in-law
  - Service providers.

Interventions and Activities

Branding:

- Brand name 'Suvidha' means convenience.
- Preferred logo design of the two flowers and two leaves was found to be very appealing and connoted '*Khushali*' or a feeling of well-being to the target groups.
- Two flowers represented two children and the leaves were the caring parents.
- Promote preferred benefits of convenience and protection from unwanted pregnancy.

Communication Activities:

- Mass Media
  - Television
  - Radio drama series for general public
  - Distance Learning program for service providers.
- IPC:
  - Counseling and follow-up card for beneficiaries
  - Counseling tools for service providers
  - Job aids for ANMs.
- Local and mid-media:
  - Posters, banners and tin plates
  - Wall paintings and hoardings
  - Folk performances.

Duration: The campaign was to be launched between January and April 2007, but was never launched because the UP government could not register the brand name 'Suvidha' for the IUD, given that a contraceptive pill existed in that name. This campaign however was revived under a new name, IUD 375, and used by the MOFHW. As of 2012, the GoI in 2012 plans to revitalize an IUD campaign.

ADVOCACY AND SKILL BUILDING

NRHM FLIPBOOK FOR ASHAS

With the establishment of the NRHM in 2005, an emphasis was given to health among rural populations. A need was felt to communicate the NRHM's mission and goals, health focus areas, and schemes of the government broadly to the populations it served. Through IPC and group meetings, ASHAs have a wide reach among populations targeted by the NRHM, and presented an opportunity to broadly and effectively communicate the NRHM's messages to members of the community.

Strategic Approach and Objectives: Provide ASHAs with a visual tool to facilitate group meetings that:

- promote the NRHM mission and goals, address health issues highlighted by the NRHM and government services available.
- facilitate talks on topics learned in the ASHA training; and
- deliver effective IPC on FP, MH, CH and RH.

Audience: Community members receiving services from ASHAs.

Interventions and Activities: Development of a flipbook for ASHAs to use during group meetings covering key issues of the NRHM. The flipbook included six sections:

- Overall health and sanitation
- MCH including ANC
- HIV/AIDS
- FP

- Adolescent health
- NRHM programs such as vaccines and disease prevention, and vitamin A and iron supplements.

Produced: 2007

Results

- 129,450 flipbooks produced and distributed to ASHAs in 71 districts.
- ASHAs found the tool very useful, and indicated that additional information in this same format on mental illness, including depression, psychosis and schizophrenia was desired.

Sensitization of PRI Leaders

Women and children in rural areas have traditionally depended upon inadequate health infrastructure and under-supported service providers. A lack of inclusion by local stakeholders, low awareness of development and health indicators, low awareness of rapid population growth and its effect on overall development and provider-driven services all contribute to the poor status of health services in the state.

SIFPSA recognized the need to improve community involvement in program implementation and set forth a strategy to sensitize political leaders and communities on MCH and the NRHM.

Strategic Approach and Objectives

- Improve knowledge and build capacity on FP and RH BCC through local, district and state level political, social and community leaders.
- Improve knowledge and build capacity for availing and managing need-based health services.
- Involve the community in sharing responsibility for their own health.

Audience

- Policymakers, political leaders, social representatives, influential community members, and officials of health and development

Needs Identified

- Information gap between:
  - Service providers and clients
  - Policymakers and communities.
- Need for a participatory and inter-sectoral approach to healthcare.
- Need to employ the NRHM's goal of assisting society to articulate its health needs, and provide a role in its management.

departments at district and block levels across 33 districts.

Duration: July–September 2007.

Interventions and Activities

Key district and block level healthcare functionaries and stakeholders across 33 districts were invited to one-day workshops where they were sensitized on the current health situation in UP, and the NRHM's vision, government policies and programs relating to MCH.

- Program management units (PMUs) organized and facilitated FP and RH sensitization workshops for influential members of the community with support from local government and NGO leaders to:
  - share health indicators of districts across UP, and UP overall; and
  - involve stakeholders in developing action and implementation plans to improve availability and management of appropriate health services based on situational analysis.
- Distribute a brochure with messages from the Chief Minister, Minister of Family Welfare, and SIFPSA Chairman and Executive Director.
  - messages provide support for administrative and managerial responsibilities of health services at the community level.
- Distribute a booklet developed specially for the panchayati raj institution (PRI) representative: "*Jan Chetana Abhiyan – ek Swastha Pradesh ki ore*" (Community Awareness Movement – towards a healthy state).
- Implement a "follow-up card" system for local contributions to health services, administrative and managerial processes.

Results

- District level workshops successfully held in 32 of the 33 focus districts, and sensitized 4,814 stakeholders.
- After district level sensitization workshops, block level workshops were organized within 32 districts; 396 out of 404 blocks held workshops (97 percent coverage). Messages providing support to community level health services management were distributed to all stakeholders at this time. For each district/block level workshop, authorities provided certification.

MID-MEDIA

COMPREHENSIVE POSTER ON FAMILY PLANNING

Aao Batein Karein

Expanding on the health information from a previous poster following a previously successful FP program, *Aao Batein Karein*, a comprehensive poster was created.

Strategic Approach and Objectives: Inform and educate men and women about:

- Contraception options available to them at clinics and from community health workers.
- Maternal, newborn and child health services available to them at clinics and from community health workers.

Audience: Single men and women of reproductive age, and couples with unmet need for family planning.

Interventions and Activities

- Develop a comprehensive poster on FP products and services, and maternal, newborn and child health services.
- Place posters in visible locations:
  - Public and private health clinics
  - Women's hospitals
  - Urban family planning centers and health facilities
  - Panchayat Ghar
  - Anganwadi centers.

Produced: 2006–2007.

Results:

- 162,767 posters were placed in targeted locations: healthcare facilities at sub-centers, CHCs and PHCs across 70 districts of UP.

Key Messages

Theme: Healthy and Happy Families

- Law supports delaying marriage until 18 years
- Educate girls
- ANC for pregnant women
- Institutional deliveries
- Immunization for children
- Postnatal care
- Health of women and babies improves economic opportunities for family
- Copper-T 380A
  - For desired family size
- Small family has benefits
- Small, healthy family leads to more prosperity.
- Men should be responsible for FP decision-making.

COMMUNITY MOBILIZATION

KUMBH MELA

Kumbh Mela is a significant religious event held every four years that attracts millions of people from all over India from different religions to partake in ceremonial holy bathing. The crowd that gathers at the mela site is a mix of people from all segments of society and from all age groups, including people with unmet need for FP, decision-makers in families, and influencers in communities who can be instrumental in bringing about necessary change in attitudes and behaviors of people towards FP. The mela provides an immense opportunity for SIFPSA to reach out with a cross-section of health messages at one place. The exhibition also offers the potential to use a mix of different media, including local media to convey messages effectively to a captive audience.

This platform had successfully been used by SIFPSA in 1995 in Allahabad, 1998 in Haridwar, and again in 2001 in Allahabad, and drew very large audiences. The 2007 event presented another opportunity for SIFPSA to utilize a proven method to disseminate health messages to intended audiences.

Strategic Approach and Objectives

Through audience analysis and community mobilization, disseminate messages about FP and RH to a captive audience through Kumbh Mela, and generate demand for FP and RH products and services.

- Using a mix of media including community level (folk media), mass media (video), and IPC (counselors), reach those who may not otherwise be reached with health messages.

Audience: Literate/Non-literate, urban/rural, men and women of reproductive ages across UP and India.

Interventions and Activities

- Kumbh Mela exhibition
  - SIFPSA pandal with a stage and scene hosted folk performances delivering BCC messages.
  - IEC panels communicated BCC messages.
  - Doctors counseled community members on client-centered FP issues and opportunities.
  - IEC/IPC materials were developed and disseminated to community members by counselors and doctors.
  - Flipbooks were utilized by counselors and doctors to convey information and educate community members.
  - Free contraceptives were provided to interested community members.

Duration: 45 days between January and February 2007.

Results

- SIFPSA estimates around 2,000 people visited the SIFPSA pandal every day for each of the 45 days. Thus, the messages spread to an estimated 90,000 to 100,000 people.
- The activities increased awareness and educated individuals on FP and healthy families, and generated demand for FP and RH products and services.

NGO PROJECTS

Folk performances are a popular form of entertainment in rural areas across India. Popular folk styles can be an effective platform, and folk troupes with experience in these styles can help convey messages to audiences with high impact. Five popular folk styles that provide a platform for the integration of FP messages include:

- Nautanki (folk theatre)
- Qawwali (traditional songs in Urdu)
- Puppetry
- Alha and Birha (traditional ballad singers)
- Magic

Strategic Approach and Objectives: To develop and deliver workshops to uniformly and rigorously train selected troupes in developing scripts that integrate FP BCC messages.

Audience: Rural communities.

Interventions and Activities: Through popular folk styles, experienced folk troupes are trained to deliver effective FP/BCC to captive audiences.

- Orient troupes on the objectives of the SIFPSA project.
- Sensitize them to the nature of the messages.
- Host interactive sessions to finalize scripts that integrate FP messages.

Duration: 1999–2007.

Results

- SIFPSA conducted six training workshops since 1999.
- In January 2007, 76 professional folk troupes were trained in all five forms of folk media.
- The performances have been rewarding for NGOs and cooperative agencies involved as platforms to disseminate their project objectives. Following performances, inquiries from audience members poured in, helping achieve objectives of taking FP to the doorsteps of families. This activity has been a major success with demands for more performances.
- Folk performances also proved useful in promoting the local community health worker and the services she can offer.
- Effectively carried FP messages to rural populations.

INTERPERSONAL COMMUNICATION

FAMILY WELFARE COUNSELORS TRAINING MODULE AND FLIPBOOK

Family welfare counselors (FWCs) are placed at government health facilities under the NRHM to provide counseling to families on social and health issues, and provide a unique opportunity to expand FP and RCH messages through community workers.

Strategic Approach and Objectives: To strengthen health messages delivered to families by frontline workers during in-house visits through enhanced counseling skills and job aids of FWCs in the areas of FP and postpartum FP, ANC, PNC, immunization and nutrition.

Audience:

- Trainers of the FWCs - *Training Manual*
- FWCs and their clients - *Flipbook*

Duration: September–December 2009.

Interventions and Activities

- Strengthened counseling skills of FWCs through the use of training manual on effective BCC.
- Provided FWCs with a flipbook that makes it easy for them to disseminate BCC messages.

Results: The training module was reviewed and piloted by FWCs, and will be used by the State Institute of Health and Family Welfare (SIHFW) for regular trainings of FWCs.

SALONI SWASTHA KISHORI YOJANA

Saloni Swastha Kishori Yojana (SSK Scheme) is a government scheme for adolescent girls designed to decrease anemia levels through the provision of iron and folic acid (IFA) tablets and de-worming. The scheme provides a unique opportunity to leverage an existing platform for the integration of BCC, and bring about sustainable health behavior change in adolescent girls.

Strategic Approach and Objectives: To introduce specific nutrition and RH themes to motivate girls to adopt healthier behaviors through IPC between teachers and adolescent girls, IPC tools, and structured group meetings.

Audience: *Teacher's Training Manual/ Teacher's Flipbook* – School teachers of Saloni Schools (where scheme is being implemented); *Saloni Diary* – for school going adolescent girls

Duration: 2009–2012

Intervention and Activities

- Created a teacher's training manual with 10 curricula on RH and nutrition.
- Developed a Saloni Diary, which is an interactive tool to record and monitor health behaviors pertaining to the nutrition and RH among adolescent girls, corresponding to the Saloni sessions.
- Created flipcharts to instruct adolescent girls on nutrition and reproductive health.
- Trained master trainers to facilitate teacher training on delivering Saloni sessions on nutrition and RH.
- Trained teachers to deliver Saloni sessions, and conduct Saloni Sabhas or group meetings in schools.
- Delivered Saloni sessions in schools, to interactive and open discussion on nutrition and RH so as to change behaviors affecting nutritional status of the adolescent girls.

FIGURE 3: BASELINE AND END LINE FINDINGS UNDER SALONI PROGRAM ON NUTRITION

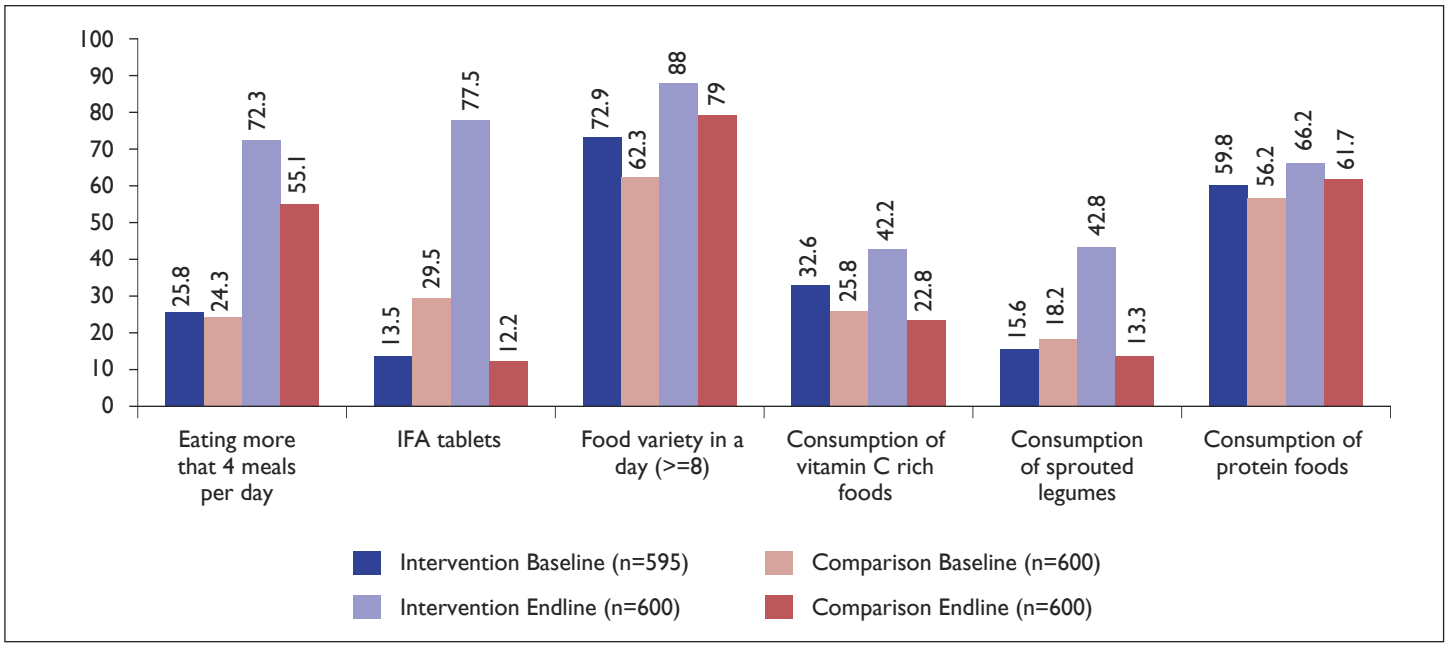
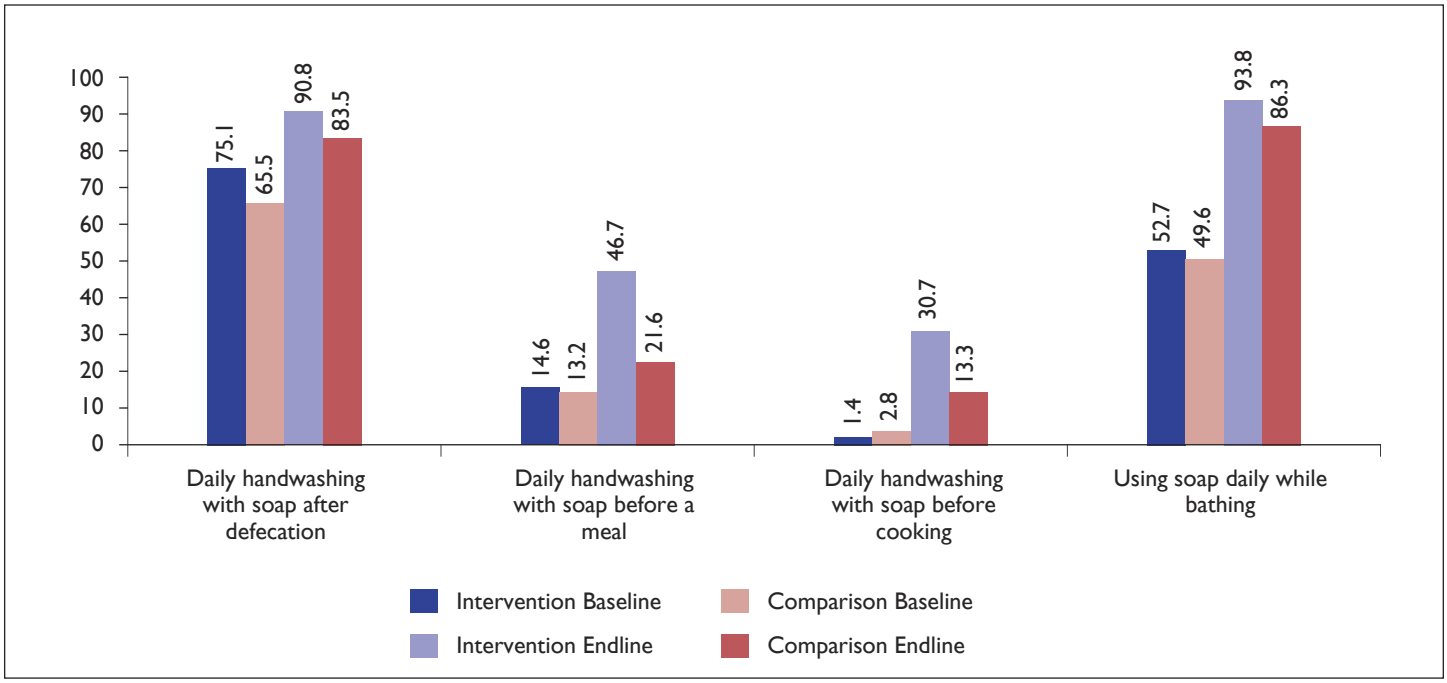


FIGURE 4: BASELINE AND END LINE FINDINGS UNDER SALONI PROGRAM ON HYGIENE



- Provided girls with a Saloni Diary for them to keep track of their nutrition and eating habits.

Results: The State Government accepted and appreciated both the Saloni Teacher's manual and Saloni Diary. They proposed printing 20,000 Teacher's Manual and 125,000 Saloni Diaries in NRHM PIP for the year 2010–11, which was approved by the Government of India. Following this, an additional printing of 410,000 Saloni Diaries was also approved by the Government of India.

A cluster randomized trial was conducted through 2009–11 in select Government junior high schools for girls in three blocks of Hardoi district to assess the impact of the one-year communication program using Saloni Teacher's Manual and Saloni Diaries.

The results indicate that there has been a signification impact in behaviors in the areas of nutrition, hygiene and RH. These include eating four times a day, adding food variety to the diet, and consuming weekly IFA tablets.

In terms of hygiene, all handwashing with soap behaviors (handwashing with soap after defecation, before eating, and before cooking) registered a significant increase. Reproductive behaviors that also improved include genital hygiene and changing cloth during menstruation three times daily. Importantly, the ideal number of children that girls wanted lowered and knowledge about the marriage law, including the penalty, increased.

PUBLIC-PRIVATE PARTNERSHIPS

SOCIAL FRANCHISING SCHEME

A significant proportion of people in India that need healthcare seek the services of the private sector, which is served by individual doctors, companies and philanthropic organizations. In Uttar Pradesh, HLFPPT launched the MGHN as a social franchising initiative through SIFPSA in partnership with USAID, Government of India and the Government of UP. The trust is committed to establish 70 Level 1 franchisees (Merry Gold) at district level as a hub to connect to the next two levels: Level 2 (L2) and Level 3 (L3). While L2 comprises fractional franchisees (Merry Silver) established at sub-division and block levels, L3 (Merry Tarang) comprises providers like ANMs, ASHA and AYUSH and acts as first point of contact with the community as well as referral support to Merry Silver and Merry Gold hospitals. The Merry Gold network provides high quality maternal and child health services at affordable prices.

This network comprises seventy 20-bed Merry Gold Hospitals, 700 Merry Silver clinics and about 10,000 Merry Tarang members. This integrated network of providers provides varied packages of services at affordable prices and works on referrals to ensure that health asset utilization is optimized and utmost value is delivered to the healthcare seeker.

Brand building: Brand building was one of the major thrusts of the program and the strategy involved creation of a brand:

- to create and sustain a franchisee network of health facility providing RCH services for the poor;
- to improve access to quality, affordable RCH services;
- to increase demand for RCH services; and
- to support to sustain program impact.

The brand Merry Gold was developed based on the marigold flower to suggest simplicity, purity, accessibility, affordability and auspiciousness. The brand includes a tag line — *"Acchi Sehat Sacchi Khushiyan"* (Good services, Real Happiness) — to signify the quality of services for the entire family.

On the basis of that creative angle, the same branding was prepared and finalized following pre-testing in three different districts of UP with perspective clients, network members, motivators etc. The majority of respondents accepted and liked the concept as it gave the impression of peace, security for loved ones, good health and trust.

The following communication products and branding were used among the general public as well as for the respective franchisees.

TABLE 11: OBJECTIVES OF THE MGHN COMMUNICATION CAMPAIGN

COMMUNICATION INTERVENTIONS	Brand Equity OBJECTIVE I	Client Load OBJECTIVE II	Expansion of Franchised Network OBJECTIVE III
	I. Brand promotion • Mass Media • Television • Local radio channel • Advt. in daily newspaper II. Advocacy • Media Advocacy • Advocacy with policy-makers • Local Media (hand bills, cable TV, wall painting, and tin plates on rickshaw) III. POS/Print • Pamphlets • Banners • Referral slips • Posters • Name plates (L3) • Signage for L1 and L2	I. Community-based activity • Door-to-Door contacts • Referral slips • Hand bills for information of health camps II. Health Camps • Free ANC checkups • FP counseling • Free distribution of FP methods III. Intersectoral Meeting • ASHA, AWW, SHGs, GP and NGOs IV. Business Model/ Motivational activities for L3/L1 • Redemption of referral slips • Incentive schemes • Merrygold Health Policy	I. Facility level activity • Special Days Celebration • Children's Day • Mothers' Day • Breastfeeding Week • Nutrition Week II. Rapport Building • 4 monthly meet for L1 • Biannual meet at L2 • Quarterly L1/L2/L3 meeting • Newsletter/Mailer III. Promotional schemes • Annual best awards for L1/L2/L3 IV. New Franchisee Development • State /District level meeting with FOGSI and other prospective franchisees

Communication Strategy: At the preliminary stage of the project, all the communication activities were focused on attracting new franchisees to enlarge the MGHN. The network was based on the following activities and interventions, which were planned and implemented under MGHN:

Results

In 2009, a mid-term evaluation was conducted. It concluded that the project was succeeding well and on its way to develop the targeted network by the end of 2010.

Project strengths:

- 63 L1 and 271 L2 facilities were operating.
- Across the network, approximately 5,500 deliveries were being performed per month along with about 22,000 ANC visits.
- By 2009, 62 percent of franchises reported that they had increased client loads by being in the system.
- Franchisees were particularly pleased with the introduction of the 13 protocols and the quality of care training.
- Consumer satisfaction was monitored and the results were encouraging: over 90 percent of users reported they were very satisfied or satisfied with the quality of service.
- Pricing had generally been maintained at new "affordability" levels ranging from 30 percent to 50 percent below average private sector charges.

The study also highlighted that consumers were satisfied with the services supplied, but did not yet stress any specifically unique brand identity or selling proposition to the network as compared to competitors. In other words, the concept of quality of care linked to low cost had yet to become a clearly distinguishing factor for the franchise. Based on these findings, the second round of the campaign was revised and launched.

As part of a review for the performance of MGHN and fully franchised hospitals, a strengths, weaknesses, opportunities and threats (SWOT) analysis was completed by

Ernst and Young in January 2011. Its aim was to revise the design of the network and financial projections for sustainability. The review indicated that there was an urgent need to revisit the brand, communication and marketing strategy for the MGHN in the light of the changed health service sector, specifically the introduction of conditional cash transfer and insurance schemes by the government through the public sector. A barrier analysis and brand equity study was then conducted to critically evaluate brand value and strength. Findings were used to design a creative brief for the implementing creative agency who would then revise the brand, communication and marketing strategy in the future to ensure increased recognition, demand and loyalty to MGHN and to make the franchise economically viable.

SOCIAL MARKETING

The term social marketing was first coined by Kotler and Zaltman in 1971 to refer to the application of marketing to the solution of social and health problems. Social marketing applies marketing principles and techniques to create, communicate and deliver value in order to influence target audience behaviors that benefit society as well as the target audience. The behavioral changes targeted can include getting the audience to accept a new desirable behavior or reject a potential undesirable behavior. Other behavioral changes can include modifying a current behavior or abandoning an old undesirable behavior.

The earliest social marketing program for contraceptives was the program launched by the Government of India for the promotion of Nirodh condoms in 1968. Subsequently, many programs have been launched in numerous countries to promote contraception. In 2006, there were 86 contraceptive social marketing programs (with annual sales of over 10,000 CYPs) running in 68 countries across the world, accounting for 39.9 million CYPs . By the year 2010, there are 93 contraceptive social marketing programs (with annual sales of over 10,000 CYPs) running in 69 countries across the world in 2010, accounting for 53.4 million CYPs.

The contraceptive market is most countries consists of two components: public (represented by the government) and private (represented by social marketing organizations, NGOs, commercial marketing organizations), which generally work in isolation from each other and often end up competing for the same markets. A total market approach represents an approach wherein the two sectors coordinate as one total market to target various population market segments.

The Indian social marketing program started with the launch of Nirodh by the Government of India in 1968. The program gradually expanded with the launch of Nirodh Deluxe, Mala-N and Mala-D. Of these Nirodh and Mala-N are intended for free distribution through the public health sector, while Nirodh Deluxe and Mala-D are socially marketed through a range of contraceptive social marketing organizations. Additionally under the Contraceptive Social Marketing Program, organizations are supported in marketing subsidized condoms and oral contraceptive pills under their own private brand names. Various organizations such as DKT India, HLFPPT, PSI India, PHSI and Janani among others are currently marketing products under the CSMP.

Objectives: To increase the Total Annual Sales of all Condoms, Total Annual Sales of all Oral Contraceptive Pills, Village Penetration in rural UP.

Audience: Men and Women in reproductive ages in Rural UP.

Duration: under the IFPS Technical Assistance Project, social marketing component started on April 01, 2007

and continued up to March 30, 2008. The one year duration of the project reflects the fact that the IFPS project itself was due to end on March 31, 2008. The Social Marketing project was extended thrice for the periods July 02, 2008 to March 31, 2009; November 01, 2009 to March 31, 2010 and December 10, 2010 to December 31, 2011.

Interventions and Activities

The project used a two-pronged strategy relying on demand generation (both generic and branded promotions) and product availability to achieve its goal of increased usage of condoms and oral contraceptive pills.

Market town activities-Weekly markets or haats are a routine affair in rural India during which the people of surrounding villages gather to sell their produce and to purchase their weekly necessities. The activity consists of use of locally acceptable folk media (nautankis – street plays, puppet shows, magic shows, etc.) to disseminate information on family planning and RCH.

Community Meetings-Outreach Workers interact and coordinate with the Aanganwadi Workers and ASHA workers to sensitize relevant target groups towards various issues including anatomy and physiology of the human reproductive system, pubertal changes, family planning and various contraceptive methods (including condoms, oral contraceptives, injectable contraceptives and intrauterine devices). The meetings used interpersonal communication techniques such as group discussions using visual aids and poster exhibitions along with condom demonstrations to explain correct and consistent use of condoms and oral contraceptives.

Healthy Baby and Mother Events-These events were conducted in association with the Village Health Nutrition Days. The Healthy Baby and Mother Events involved women who have infants and young babies who then serve as a captive audience for promoting the concept of family planning. The link between family planning (in the form of spacing between children) and maternal health leading to healthy babies will be explained. These events have also been used as a forum to educate mothers regarding child nutrition, immunization and other selected issues.

Van activities / Poster exhibitions-Van activities were especially focused towards a woman audience. This helped counter the male dominated audience present at the Market Town Activities. Vans decorated with promotional materials were used to reach the targeted villages. The staff traveling with the van carried exhibition sets based on family planning and promoted the message directly to end-users through the exhibition of promotional materials and distribution of literature. The activity also resulted in spot sales.

Umbrella activities-Umbrella activities were organized at various places where people are expected to gather, such as melas, bus and railway stations and special days under NRHM. The activity consisted of a stall along with a garden umbrella at the venue with a poster exhibition providing messages on contraceptive methods and family planning. The intent was to create a discussion among the participants regarding the messages exhibited. This was skillfully guided and moderated by the project staff present. Spot sale of oral contraceptive pills and condoms was also conducted during this activity in an attempt to induce trial.

Results: Between 2008 and 2009

Activities Conducted

- More than 13,000 Market Town Activities conducted reaching 945,000 men and nearly 315,000 women
- 430 Village representatives meetings conducted
- 21,300 community meetings conducted
- 780 retailer meetings conducted, attended by 17,000 retailers
- 145 community based distributor (CBD) meetings conducted, attended by more than 4000 CBDs

Findings

- Retail outlets in rural villages are willing to stock condoms and pills if product is made available to them
- Total sales in 2008-09 in rural UP
  - Condoms: 159 million pieces
  - OCP: 2.99 million cycles
- Number of retail outlets stocking condoms is higher than those stocking OCPs
- Innovative approach to mid level IPC such as market town activities strengthen both supply and demand
- IPC is essential for consistent and correct messages on usage of products and management of side effects, especially for pills

VOUCHER SCHEME

The voucher scheme is a demand-side financing model that enables families in urban slums to access critical RH services, while empowering them to choose the provider they want. To achieve this, affordable, accessible and quality RCH and FP services are provided to below poverty line (BPL) families in the city through accredited private facilities using a voucher scheme model.

Uttar Pradesh has learned from its own experience of implementing the voucher scheme. A voucher system was piloted in Agra and Kanpur Nagar covering seven rural blocks of Agra and 368 urban slums of Kanpur Nagar. The focus population was women of reproductive age and children up to two years old from vulnerable families. The services provided included ANC, delivery in a health facility, PNC, FP and RTI/STI.

The voucher scheme encourages beneficiaries to use these services by providing vouchers that allow women to obtain services from private sector providers free-of-charge. Due to this, increased uptake of services provided in the scheme to the target BPL families has been very encouraging.

Based on lessons learned and the performance of a pilot project conducted in Kanpur Nagar, the voucher scheme was scaled up to urban slums in Agra, Kanpur, Varanasi, Allahabad and Lucknow.

Audience: Urban slum populations.

Duration: 2009–2011.

Interventions and Activities

- Development of voucher communication strategy in the State.
- Development of communication material as elaborated in Communication Strategy.
- Development of street play script for community mobilization.
- Developing training package and impart training to Voucher Distribution Agency Staff: voucher coordinator, assistant voucher coordinators (AVCs) and community health volunteers (CHVs).
- Training of voucher distribution staff.
- Home visits and group meetings by CHVs and distribution of vouchers.

Results

- Voucher distribution staff trained in KAVAL towns on voucher distribution system, basic RCH issues and IPC.
- AVCs in KAVAL Towns are trained on FP counseling so as to increase uptake of FP vouchers.
- Voucher uptake and utilization of services.

Janani Shishu Suraksha Karyakram (Mother and Child Safety Program)

JSSK is a government scheme launched in the State of UP in 2010. The scheme aims to provide cashless delivery services to the women delivering at a government health facility. The chartering of services has been developed for this program. To establish the program, SPMU–NRHM was supported to develop the radio spots and jingles.

Strategic Approach and Objectives: Make pregnant women and their families aware of entitlements under the scheme by putting up a charter at the reception, waiting area, female ward and labor room of the facilities where the scheme is operational. Establish the scheme among the general rural population through radio, which has the highest reach to the farthest areas of the State.

Audience:

- Charter – Pregnant women and their families.
- Radio Spots and Jingles – General rural population.

Interventions and Activities

- A Service Charter was designed on the basis of GoI guidelines and services offered by the State Government to place within the facilities.
- Scripts for the Radio Spot and Jingle were developed and vetted by a committee comprising experts from SPMU IFPS project.
- Spots and Jingles were produced after the script was approved and then heard and reviewed by a committee comprising experts from SPMU, SIFPSA, FW Directorate, IFPS project and AIR.
- The Listening Committee's suggestions were incorporated.

Duration: September 2011–onwards.

Results

- 1000 charters were placed in facilities identified for JSSK.
- The final spots and jingles were handed over by the SPMU to AIR.

LESSONS LEARNED AND PROMISING APPROACHES

The comprehensive approaches employed in UP to increase awareness and generate demand for improved health required a high level of coordination and support from stakeholders at all levels. While the comprehensive strategy and implementation plan was effective at improving the availability and delivery of healthcare services across the state, decentralization was also found to be helpful.

- Health functionaries in far reaching corners of the state are reliable, credible, and sometimes the only source impacting the health of their communities.
- ASHAs may deliver the only healthcare men and women will receive in the most remote parts of UP, and must be well-trained and provided with adequate resources to make an impact.
- PRI Leaders may be the most effective influencers of health policy in their communities if they are sensitized and trained in the status of health in their districts, and the resources available to them through national or state level schemes.

The development of BCC visual aids such as toolkits and flipbooks and distance learning radio programs was found to be very useful for educating healthcare workers, and disseminating health messages to community members. Additionally, UP's close-knit communities and its key stakeholders were committed to improving health, and were effectively mobilized to improve health status under an overarching and broad-based strategy and implementation plan. The following were key to the project's success in UP:

- Develop an overarching BCC strategy for all levels of administration within the healthcare sector through collaboration and participation.
- Build capacity for synergistic BCC, program design and implementation across all levels of service delivery — national, state and local; and among families, communities and facilities through events such as workshops and tools such as informative flipbooks.
- Scale up programs and increase reach through expanded capacity building efforts, and participatory BCC tool design and deployment.
- Brand and promote products and services from healthcare resources to communities, ASHAs and Merry Gold Network franchisees.
- The Kumbh Mela event was again effective in reaching large audiences in cost-effective ways through proven BCC platforms such as folk media and IPC.

What Works

- Overarching strategy.
- Capacity building across all levels of strategy implementation.
- Inclusion, collaboration and participation across all functions.
- Reinforcement and expansion of messages.
- Disseminating messages across multiple mediums to captive audiences through institutionalized events:
  - Mass media
  - Community folk media
  - IPC and counseling.

SECTION 3

Behavior Change Communication

Jharkhand

The Power of Innovations and Partnership

STATE BEHAVIOR CHANGE COMMUNICATION STRATEGY

DEVELOPMENT OF THE JHARKHAND BCC STRATEGY

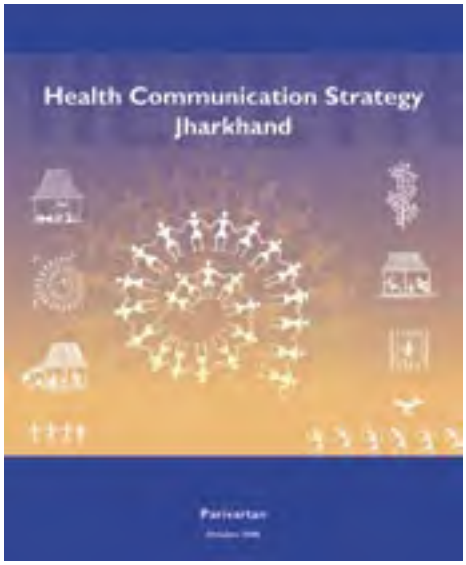
The role of strategic communication is critical for the NRHM to achieve its objectives in Jharkhand, and they recognized the need to move from an event-oriented and isolated approach for addressing health issues, to a collaborative and comprehensive approach. A comprehensive strategy that addressed priority health areas through an integrated and multi-channel BCC approach was needed to improve health and impact infant mortality, maternal mortality and fertility rates in the state.

Strategic Approach and Objectives: Develop a comprehensive BCC strategy for priority health areas to:

- enhance awareness, generate demand and facilitate behavior change in specific target populations for health services related to FP, MH, CH, HIV/AIDS and ARSH, to improve indicators of IMR, MMR and TFR;
- build trust in and improve the image of the health system, by increasing the IPC skills of providers through training and capacity building, and by creating linkages between the private and public sectors to ensure quality of services; and
- create an enabling and supportive environment through community-based dialogue, advocacy and social mobilization.

BCC Strategies for Jharkhand

- Integrate mass media with community level media and IPC activities to increase the Opportunity to See (OTS) of the health campaign.
- Use of radio for specific health messages to ensure maximum reach in a cost-effective way.
- Extensive use of IPC and mid-media in rural and hard-to-reach areas.
- Leverage existing social networks, festivals and cultural practices to disseminate health information more widely.
- Identify existing supply points such as chemist outlets, PHC and cinema halls to reach large numbers of people with reminder health messages.



Audience:

Primary audience:

- Men and women of reproductive age

Secondary audiences:

- Parents, community leaders, faith leaders, health service providers, traditional healers, local governance bodies, private-sector practitioners.

Interventions and Activities: The *Parivartan* ("Change") BCC strategy was developed by the IFPS project, USAID and leadership from the Jharkhand Department of Health, with inputs from all stakeholders working with the state under various health programs.

- A situational analysis identified the current health scenario, IEC efforts and gaps to gain insights on the issues faced in the state;
- Participants and stakeholders worked in groups through two workshops to develop a BCC matrix and identify primary and secondary audiences, underlying social barriers, and the tools and channels recommended to achieve desired outcomes:
  - A development workshop initiated by the Health and Family Welfare department and supported by IFPS project using the results-oriented framework was held in Ranchi in March 2007 to:
    - explore the role and importance of evidence-based strategic communication;
    - prioritize health areas to be addressed; and
    - identify barriers to the adoption of health behaviors and promising interventions.
  - An implementation planning workshop was held in May 2007.
- A strategy framework was proposed to work as a blueprint to guide IEC/BCC campaigns and efforts for the state and its partners. Strategies for focused and targeted interventions under FP, MH, CH, HIV/AIDS and ARSH were identified.
- A monitoring and evaluation implementation plan was drafted.
- Various levels within the Government of Jharkhand, IFPS project and USAID provided inputs for and revised the communication strategy for the development of a final document.

Print Date: October 2008.

Results and Key Recommendations of the BCC strategy

The Health Communication Strategy for Jharkhand, Parivartan was formally launched on November 18, 2008 by the then Health Minister Shri. Bhanu Pratap Sahi. Ms. Monique Mosolf, Chief, Reproductive Health Division, USAID was also present.

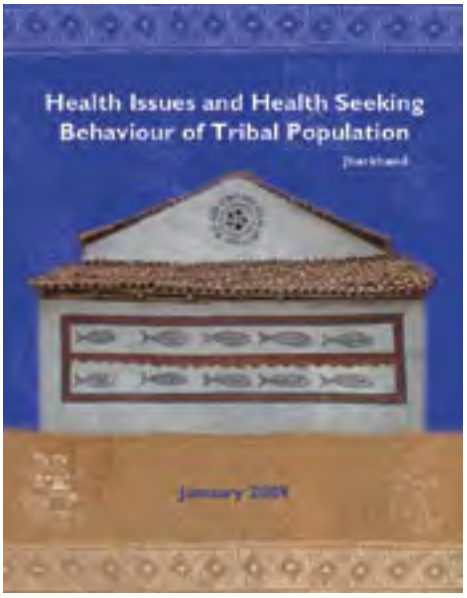
The BCC strategy recommends the following nine activities:

1. Conduct a Behavior Change Impact Survey (BCIS) for developing baseline indicators and formative research across a broad range of health issues for developing communication concepts.
2. Conduct an assessment of different media outlets available in the state, including mass media, in order to understand the reach of different channels.
3. Finalize the development and implementation of two integrated multimedia campaigns on birth spacing and MH.
4. Initiate PPP models for introduction of new contraceptives, e.g., SDM and DMPA in the state.
5. Develop and implement IPC training protocols, manuals and materials for health providers to support IPC and group sessions on prioritized health issues.
6. Identify and ensure visibility at both public and private health facilities about the availability of immunization services.
7. Initiate PPP models on prioritized adolescent health issues.
8. Develop capacity of health providers to provide information and counseling to adolescents.
9. Introduce a telephone helpline to disseminate information on HIV/AIDS and other priority health issues.

ADDRESSING NEEDS OF SPECIAL POPULATIONS

HEALTH ISSUES AND HEALTH SEEKING BEHAVIOR OF TRIBAL POPULATIONS DOCUMENT

Jharkhand is home to over 30 tribes that make up 26.3 percent of the total state population (Census of India, 2001). There is a strong need to identify information gaps in health practices and service utilization of Jharkhand's tribal population as there have been constraints in addressing their requirements through effective policy measures and service delivery programs (*Health Issues and Health Seeking Behavior of Tribal Populations,* January 2009). To improve health service utilization among these populations, it was important to identify barriers to access that were unique to these tribes, and understand cultural and social factors that could aid in reducing barriers and increasing access. The Government of Jharkhand, in collaboration with the IFPS project, wanted to understand behaviors, rituals, beliefs and remedies related to RCH followed by the Santhal, Munda, Oraon and Ho tribal groups in the Santhal Pargana and South Chotanagpur regions, and better understand the interplay between the physical and political environment within these select tribal groups.



Strategic Approach and Objectives: Identify, understand and analyze existing health seeking behavior of couples in major tribal groups with a focus on the traditional system of healing, through a comprehensive qualitative assessment.

Objectives of the assessment:

- Identify the key behaviors, traditional rituals, beliefs, practices and remedies followed during critical stages related to health and disease.
- Assess the knowledge level, utilization and traditional practices related to contraception.
- Identify treatment-seeking behavior during pregnancy, delivery and post delivery period.
- Examine the rituals and practices related to newborn care and breastfeeding.
- Identify the beliefs and perception about RTI/STI issues.
- Identify existing healing rituals, perception about the existing health system, the role of indigenous medicine among the tribal population and integration of traditional medicine with the prevailing RCH program among the traditional service providers and providers from the mainstream health system.

Audience: All stakeholders at all levels working in Jharkhand under various health programs.

Interventions and Activities: A qualitative assessment was conducted and a final report produced that identified underlying barriers of geographic access, economic constraints and cultural issues to be addressed in order to improve health service utilization.

- Samples were drawn from Santhal, Munda, Oraon and Ho tribes, and a minority tribe, Pahariya, and unique tribal characteristics and differences were documented.
- Social mapping was carried out to list resources and utilization of services.
- Force field analysis, listing and pile sorting for perception of health system and treatment seeking behavior was completed.
- Key informant interviews were conducted with:
  - ANM, AWW, and traditional birth attendant (TBA)
  - Local registered medical practitioners (RMPs), who practice in the villages
  - Village-based traditional healers
- In-depth interviews were conducted with:
  - At least one woman/couple with experience of an neonatal death

- At least one respondent with experience of maternal disease or death in the household.
- Focus group discussions were held with eligible couples.
- For each tribe, key informant interviews were conducted with:
  - Social activists
  - Herbal practitioners (specialists)
  - Modern doctors and health workers at Mission hospitals and government hospitals.

Print Date: October 2008.

Report Findings and Recommendations

Situational analysis

- Tribal populations have led impoverished lives and the state is ranked at the bottom of most development rankings.
- Less than 10 percent of villages have electricity, and they lack roads and institutions in health, education and services for women and children.
- Healthcare problems stem from illiteracy, poor infrastructure, poor sanitation, and some customs and traditions unique to tribes.
- Programs by the GoI to improve welfare among tribal populations have not impacted health service utilization; however, there is willingness among stakeholders to engage traditional and government systems if opportunities are made available.

Recommendations for Tribal Populations

- There is an immediate need to ensure availability and accessibility of services to tribal and rural populations, and institute tribal-friendly health services in remote areas.
- There is a large unmet need for FP, and opportunity to promote tubiligation and IUDs.
- There is also a need to reconsider the Primitive Tribal Groups (PTG) policy that bans the promotion of FP among endangered tribes.
- Integrated Child Development Services (ICDS) scheme must be universalized and quality output should be monitored in child healthcare facilities. ICDS data must be disaggregated to understand and inform policy and action.
- Empower local populations to plan for and monitor health at the hamlet level through Village Health Committees and *Sahiyyas*.
- Ensure functional health and nutrition facilities in every village:
  - Anganwadi center in each village
  - Adequate and efficient health sub-centers
  - CHCs and PHCs for tribal areas in all scheduled districts.
- Ensure healthcare facilities are tribal-friendly with workers from tribal villages fluent in local dialects.
- Encourage local tribes to manage public relations.
- Institutionalize traditional healing practices through universities and research institutes, promote *vaid raj* in each village, and document and provide platforms for sharing and dialogue.

Accessibility of health services

- Most modern health services are provided by local RMPs.
- ANMs are less available in remote areas.
- AWWs are present but do not deliver healthcare services.
- Traditional doctors (*vaid rajs*) and untrained birth attendants (*dais*) are accessible, however, not integrated with the government healthcare system.

INTRA COMMUNICATION

INTRA-COMMUNICATION WORKSHOP FOR THE JHARKHAND HEALTH SOCIETY (JHS)

The MoHFW, GoI has initiated a move for intra-communication amongst the stakeholders of the public health delivery system. This initiative under the NRHM aims at optimizing organizational synergies through intra-communication. The IFPS project is engaged in working with the Government of Jharkhand to improve the capabilities and deliveries of the public health system in the state through communication. As part of this effort, the IFPS project has undertaken a pilot initiative to deliver and evaluate the effectiveness of intra-communication capacity building activities.

Strategic Approach and Objectives: Through a participatory process, build capacity for intra-communication between Jharkhand health program managers and workers to build skills in employing basic concepts of communication, and add value to the process of developing district IEC plans.

Audience: ANMs and doctors.

Duration: December 2007 – March 2008.

Interventions and Activities: Workshops were held in two districts, Deoghar and Lohardaga. Workshop sessions employed interactive and participatory approaches such as question-and-answer sessions, anecdotes, games, team exercises and practice sessions. Topics covered included:

- Elements of communication processes
- Basics of effective communication
- Identification of communication tools (IPC, mid-media, mass media).
- Development of simple reporting and monitoring formats.
- Development of templates for community wall newspapers.

Results

- Thirty-two ANMs and 16 doctors participated and gained skills in effective IPC, report writing, use of IPC tools such as flipcharts and posters, and designing and developing wall newspapers and newsletters.
- ANMs expressed a willingness to write event reports following visits with clients, and to use IPC tools taught through the workshop to improve their communication skills.
- A core team of ANMs and doctors in each district was equipped and motivated to lead the intra-communication initiative in their communities following the pilot.

IPC CAPACITY BUILDING OF *SAHIYYAS*

Effective IPC between healthcare providers and clients is one of the most important elements for improving client satisfaction, prevention, treatment adherence and health outcomes. Effective IPC also benefits the health system by making it more efficient and cost-effective. Thus, clients, providers, administrators and policymakers all have a stake in improved provider – client interactions. The Government of Jharkhand recognized the need for more effective IPC among *sahiyyas*.

Strategic Approach and Objectives: Through a TOT and subsequent cascade training model, build capacity for IPC and counseling skills among Sahiyyas and ANMs.

Audience: Sahiyyas and ANMs from the Bokaro and Gumla districts.

Interventions and Activities

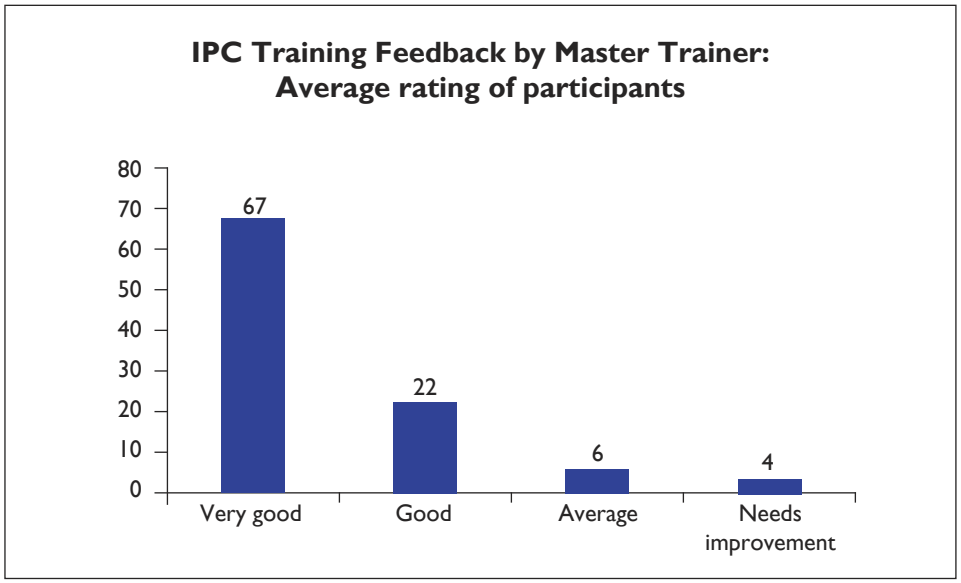
- A model TOT plan on IPC focusing on client–provider interaction was developed.
- Training material prototypes, curricula, and job aids were developed, pre-tested and finalized.
- A TOT Toolkit was developed with materials for master trainers and *sahiyyas*.
- A follow-up and supervision plan was developed.
- TOT training sessions were delivered:
  - Three-day trainings trained master trainers on the GATHER approach, strengthening their training skills.
  - Mock training sessions with feedback from facilitators were held with master trainers.
- An assessment of the training was conducted.

Duration: August 2009

Results:

- Through pre-testing, 10 master trainers and 20 *sahiyyas* identified changes for the development of the final training module and materials.
- 122 master trainers were trained over five sessions.

FIGURE 5: IPC TRAINING FEEDBACK (PARTICIPANT RATING)



- 67 percent of participants rated the training as very good:
  - Most liked sessions were those with role plays of counseling situations (78 percent of participants), mock training sessions (67 percent), and steps of counseling (56 percent).

G Greet client (establish rapport)
A Ask client (gather information)
T Tell (provide information)
H Help client with problem-solving and decision-making
E Explain to the client key information for the decision
R Return/Refer/Reality check

Toolkit Materials for *Sahiyyas*

***Sahiyya* Box**
An easy-to-carry box with contraceptive samples and takeaways for use as a facilitation and demonstration tool.

Reference Book
A book for *Sahiyyas* on FP with case studies from the field. This booklet fits into the toolkit.

Takeaways
40 takeaways for men and 40 takeaways for women that *Sahiyyas* leave behind after counseling, with information about contraceptive choices for men and women separately.

Toolkit Materials for Master Trainers

Facilitator's Guide
It includes detailed training curriculum and agenda to train and supervise *Sahiyyas* in IPC.

Instructional Video on Counseling Steps for FP
It includes case studies that can be analyzed to understand steps of counseling and skills of a good counselor.

Sahiyya Materials
All the materials that the *Sahiyyas* have in their toolkit.

DEMAND GENERATION FOR FP SERVICES

BCC strategy and campaign for Sambhav Voucher Scheme
Many FP and RCH services are not available or are inaccessible to vulnerable populations through the public healthcare system, and often, poor families are forced to seek services from a costly and unregulated private sector, causing severe economic distress. This is a major barrier to accessing services for the most vulnerable populations. The rate of healthcare service seeking through private health providers in Jharkhand, as in all of India, is high, with over two-thirds of the population seeking private services.

The voucher scheme allows the government to reduce the financial burden of the poor when they access services in the private sector by linking vulnerable groups to critical FP and RH services free of cost at accredited private health centers. The voucher scheme provides low-income families with a set of coupons, given by ASHAs or *Sahiyyas*, to obtain free FP and RCH services from designated providers. The government reimburses private healthcare providers for services performed under the scheme on a previously agreed fee schedule, and monitors services to ensure high quality.

Effective IPC between healthcare providers and clients further impacts healthcare seeking and service utilization, and is recognized as one of the most important elements for improving client satisfaction, adherence and health outcomes. Effective IPC also benefits the healthcare system as a whole by making it more efficient and cost-effective. Thus, clients, providers, administrators and policymakers all have a stake in improved client–provider interactions. Effective IPC was therefore determined to be of critical importance to improve service utilization throughout the private sector.

There was a need to increase awareness, access to, and use of FP and RCH voucher services through private providers through demand generation BCC and more effective client–provider IPC.

Strategic Approach and Objectives: Develop and deliver demand generation activities for BPL populations to increase healthcare seeking and service utilization through private healthcare providers using the voucher scheme.

- Generate demand for use of the FP voucher scheme through increased awareness and knowledge.
- Generate demand among BPL populations for the use of the FP voucher scheme through private healthcare facilities by increasing knowledge and awareness, and increase use of services for:
  - No-scalpel vasectomy (NSV)
  - Female sterilization
  - IUD
  - Injectables
  - Condoms
  - OCPs
  - Standard Days Method.
- Improve effectiveness of IPC and build counseling skills of *Sahiyyas*, ANMs and AWWs.

Audience

- Couples with one or more children
- Couples who have reached their desired family size and wish to have no more children

- Mothers-in-law and other key decision-makers within the household
- Service providers in the public and private sector.

Duration: 2008–2010.

Interventions and Activities

- Completion of a communication needs assessment to analyze:
  - access to information on FP (methods, importance, use, benefits and barriers);
  - knowledge about availability of FP services;
  - preferred source of services and products, and reasons for preferences;
  - motivating factors and barriers to FP service access and adoption;
  - identifying myths and misconceptions related to FP methods; and
  - preferred and available channels of communication.
- Testing of existing voucher scheme, demand generation materials from Uttarakhand including flipbooks, leaflets and posters to determine if materials were relevant or adaptable to Jharkhand based on:
  - comprehension and appeal of messages, flow of content, and visuals;
  - retention of visuals and messages;
  - cultural relevance of visuals and messages; and
  - appropriateness of type of materials: visibility, ease of handling, portability and ease of material dissemination and storing.
- Capacity building training on IPC for *Sahiyyas*, ANMs and AWWs with semi-annual meetings for problem-solving and sharing of best practices and lessons learned.
- Develop a Voucher Management Agency (VMA) to manage the scheme with responsibilities of:
  - identifying intended beneficiaries;
  - Training healthcare staff at accredited private hospitals on quality standards;
  - establishing a financial disbursement system for advancing funds and reimbursing private hospitals for voucher services;
  - managing project management information system (MIS), conducting periodic quality audits, and seeking beneficiary feedback; and
  - disbursing and managing incentives given to *Sahiyyas*, and the reimbursement of transportation costs to beneficiaries.

MID-MEDIA STREET PLAY CAMPAIGN

Under the IFPS project supported activities in Jharkhand, special efforts to increase the awareness and demand for FP and RH in the state have been initiated. Under this initiative, the state empaneled troupes were trained in performing a street play on FP and RH, that was based on BCC and EE approaches. The program involved the eminent Darpana Academy of Performing Arts, headed by Dr. Mallika Sarabhai (Indian Classical Dancer and social activist from Ahmedabad, Gujarat) to train the troupes and perform over 150 shows in the three districts, namely Simdega, Giridh and Chaibasa, which were identified by the state to implement the interventions and conduct the folk plays. The trained state folk troupes performed similar plays in other districts through NRHM funds.

Strategic Approach and Objectives: The street play compared two families: one with only one child and the other with many children. In doing so, it addressed several FP/RH topics, including the ideal age of marriage for girls, delaying the first child, the benefits of spacing children three years apart and limiting family size to two children. The play examined the health, economic, quality of life and relationship consequences that resulted from the FP decisions made by each family.

Audience: Men and women of reproductive ages in tribal districts and community influencers.

Interventions and Activities

- Six troupes were trained, of which four troupes were selected to conduct shows at the village level. The play used the EE approach which states that communication can bring about a change in attitudes and perceptions if it caters to the head and the heart. Thus, more than informing or creating awareness, the messages or events or stories trigger an emotional response in the audience, make them realize, contemplate and move towards change. This was accentuated with the use of local folk tunes, themes, songs and background effects.
- The play discussed the ideal age of marriage for girls, delaying first child, benefits of spacing for three years and limiting family size after two children (be it girls or boys) by comparing two families — one with lots of children and other with just one child. In doing so, they see the impact of too many children, closely spaced on economic condition, quality of life, inter-spousal relationship and the health of the woman and child. The audience was shocked when the woman with her sixth child screams with labor pains and is taken through the audience by the other characters, and even more when they hear the baby dies during delivery. The audiences contemplate their own lives, when the father of the dead child realizes he should have listened to his wife and adopted a contraceptive method long time ago. Post-performance discussions and exit interviews aided in checking if the audiences understood the key messages.

Duration: The street plays were performed in the months of April and May 2011 each, drawing about 250 spectators including men and women of reproductive age, family elders, adolescents and children. Being the summer season and agriculture having

taken a back seat, more men turned up to watch the shows. It was very well appreciated by the state.

Results:

An impact assessment was conducted in November 2011, seven months after the intervention, using a quasi experimental design, where the respondents were men and women of different parity (experimental villages were the ones that were exposed to the play (452 interviews and control villages=284 interviews). The findings were:

- Of the total, 57.7 percent were aware of the play and 46.5 percent attended the plays. More than 40 percent of informants heard announcements on microphones on the troupes' vehicle.
- Over 87 percent recalled theme of the play as FP and over 60 percent recalled them as benefits of a small family.
- Over 60 percent recognized the impact of large family size on health of the mother and child and family finances. Characters recalled included woman with one child (69 percent), doctor (55 percent), narrators (50 percent), puppets as children (40 percent) indicating high recall.
- 92.6 percent found the play entertaining and 100 percent educational.
- The play was seen as different due to use of puppets (58.3 percent) and songs before and within the story (34.4 percent).
- The play was acceptable, relevant and believable (over 96 percent) and 67.4 percent found close to life.
- 92.1 percent discussed with their spouses and 78.4 percent encouraged their friends and neighbors to adopt FP methods indicating that the message of male participation and inter-spousal discussion were internalized.

LESSONS LEARNED AND PROMISING APPROACHES

Lessons were learned through the development of the Jharkhand BCC Strategy, and findings from the evaluation of healthcare seeking practices of special populations indigenous to Jharkhand, as well as from the formative assessment of voucher scheme materials.

- A collaborative, inclusive and participatory approach is critical to the adoption of programs and services for specific populations where social and cultural factors heavily influence behavior at all levels.
- Individual campaigns or isolated approaches are less effective than activities stemming from a broad, evidence-based, data-informed strategy.
- BCC programs that integrate health topics, BCC messages and complimentary delivery approaches — such as state level mass media promoting services through ASHAs, and a community level folk performance demonstrating ASHAs' skills — can effectively reinforce messages to intended audiences.
  - This was demonstrated through the state strategies developed and implemented in both Jharkhand and UP.

BCC activities implemented in Jharkhand highlight the unique needs and opportunities for health behavior change. Through strategy development, intervention delivery and evaluation, several promising approaches for effective BCC were demonstrated in Jharkhand.

- Strategic BCC planning that follows proven models of health communication and includes a situation analysis, communication objectives, priority areas for focus, and training and capacity building of key healthcare providers in facilities and communities; and consideration and strengthening of operational capacities can be a very effective approach for comprehensive and coordinated BCC.
- BCC development through a collaborative, integrated and coordinated process that includes multiple levels of stakeholders in the public and private sectors, and representatives from special populations can successfully empower communities and healthcare providers to develop and deliver the most culturally and socially relevant programs.
  - Audience segmentation and tailored intervention delivery mechanisms to segmented audiences is necessary to reach communities that are diverse and may pose additional challenges, such as tribal populations in Jharkhand.
    - Capacity building of ANMs and ASHAs who are the only health service providers accessible to some tribal communities, and training and inclusion of traditional healers in

service delivery plans effectively demonstrated this approach.

- Empowerment of frontline healthcare providers such as private doctors, ASHAs, ANMs and master trainers through capacity building, and the provision of culturally appropriate tools can effectively increase knowledge, generate community demand, and improve healthcare service utilization.
- EE approaches work very well in designing impactful messages and content that provide information and also touch people emotionally and psychologically.

WHAT WORKS

- Collaborative, coordinated approaches to BCC strategy development.
- Inclusion of special or at-risk populations in BCC development.
- Consideration of unique cultural and social factors in barriers and behavior change interventions for healthcare service usage.
  - Tribal populations may have needs and opportunities not previously explored.
  - Demand generation for healthcare services in tribal communities relies upon well-informed solutions.
- Empowerment of frontline healthcare providers is key to effective BCC.
  - Well-trained and well-equipped frontline workers in the private and public sectors can increase demand for FP healthcare products and services.
- EE approaches to story telling.

SECTION 4

Behavior Change Communication

Uttarakhand

The Power of Innovations and Partnership

BEHAVIOR CHANGE COMMUNICATION

MASS MEDIA

Institutional Delivery Campaign Based on a formative research study conducted in 2006, it was found that populations in Uttarakhand prefer home deliveries. Rates of women delivering in an institution and delivering with a trained health professional are lower in Uttarakhand than in India overall.

TABLE 12: NFHS-3 DATA ON BIRTH DELIVERY (INDIA AND UTTARAKHAND)

NFHS–3 (2005-06)	Uttarakhand	All India
Births delivered in a health facility	32.6 percent	38.7 percent
Births delivered by a trained health professional	38.5 percent	46.6 percent

In mid-hill and upper-hill regions, accessibility to service delivery points and faith in TBAs (*dais*) are key determinants for home delivery preference over institutional delivery. In the lower plains, low cost of delivery at home, coupled with a home-focused environment and faith in *dais* are key factors for preferring home delivery to institutional delivery. The general

practice is that institutional deliveries are chosen in case of emergencies or when a *dai* refers the family to a hospital or health center due to birth complications.

Strategic Approach and Objectives: Through mass media, promote the benefits of institutional births, focusing on increasing delivery in the private sector through:

- Increased awareness and utilization of the JSY which provides incentives for institutional delivery.
- Increased knowledge of birth danger signs and complications.
- Increased knowledge of birth preparedness and birth planning.
- Increased awareness of and confidence in ASHAs in delivering BCC for FP and RCH services; and
- BCC materials that utilize appropriate language, cultural and social representations.

Audience:

- **Primary:**
  - Couples of reproductive age and newly married couples.
- **Secondary:**
  - Mothers-in-law or elder women, and women heads of households.
  - Healthcare providers, specifically ASHAs, ANMs and hospital staff.

TV Airings

Doordarshan	12 times daily
TV-100	4 times daily
Sahara Samay	4 times daily
ETV Uttarakhand	4 times daily

Duration: Aired in September 2007, and was repeated between January–March 2009.

Interventions and Activities:

- Identify a campaign promise and benefit: *"Enroll yourself today in the JSY program and ensure a safe, secure and affordable*[3] *environment for delivery of your baby"*.
- Develop samples of creative ideas for printed materials including brochures, calendars, posters, stickers and "Q" cards illustrating the JSY program and how to access the program and its benefits.
- Develop IPC materials for community healthcare workers.
- Develop folk media scripts and mass media TV or radio spots:
  - A media plan was developed to ensure high reach and frequency for key audiences.
- Provide the spots to the Uttarakhand Health Society for airing on TV and radio, and printed materials for distribution.

Results:

The materials and media plan were provided to the Uttarakhand Health Society. TV spots were aired 24 times daily on national and regional channels during the promotion period.

[3] Affordable: The JSY program is meant for BPL families, but the program does not exclude non-BPL families in delivering a baby at public health facilities.

CHILDHOOD IMMUNIZATION CAMPAIGN

Rates of childhood immunization for any illness in Uttarakhand are generally better than rates for all of India. On the other hand, there are almost twice as many children in Uttarakhand that do not receive vaccinations compared to India overall. However, the higher rates of full and disease-specific vaccinations for Uttarakhand children highlight the importance of initiating the immunization cycle and increasing the potential for disease-specific and full vaccinations for healthier children across the state.

TABLE 13: NFHS-3 DATA ON IMMUNIZATION (INDIA AND UTTARAKHAND)

NFHS-3 (2005-06)	Uttarakhand	All India
BCG vaccine for TB	83.5 percent	78.1 percent
Polio 0 (at birth)	51.8 percent	48.4 percent
Measles	71.6 percent	58.8 percent
Full vaccination	60.0 percent	43.5 percent
No vaccination	9.1 percent	5.1 percent

Strategic Approach and Objectives: Develop a communication strategy that focuses on reducing high vaccination dropout rates and achieving 100 percent routine immunization in Uttarakhand by:

- Promoting "full immunization" for children before their first birthday.
- Encouraging every parent to finish a series of vaccine visits at health centers or a place where immunization services are provided before the first birthday of the child; and
- Improving image of the health workers who administer vaccines among parents and communities.

Audience:

- Primary:
  - Caregivers (fathers and mothers) of children under 12 months, 18–30 years, living in rural and urban areas who have not fully immunized their children.
- Secondary:
  - Elders in the family, and village influencers including religious leaders, ANMs, ASHAs and AWWs.

Duration: Launched in September 2007 and repeated between January–March 2009.

Interventions and Activities:

- Identify a campaign promise and benefit: *"If you have fully immunized children, you will join the family of proud and responsible parents whose children are protected against six killer diseases".*
- Develop samples of creative ideas for printed materials including brochures, calendars, posters, stickers and "Q" cards to increase access to the program and its benefits.
- Develop IPC materials for community and facility healthcare workers.
- Develop plans for outreach activities to increase attendance at public health facilities on immunization days.
- Develop folk media scripts and mass media TV or radio spots.
  - A media plan was developed to ensure high reach and frequency for key audiences.
- Provide the spots to the Uttarakhand Health Society for airing on TV and radio, and printed materials for distribution.

Results: The materials and media plan were given to the Uttarakhand Health Society. TV spots were aired 24 times daily, nationally and regionally during the promotion period.

MULTIMEDIA CAMPAIGN

SAMBHAV VOUCHER SCHEME– BCC STRATEGY AND MULTIMEDIA CAMPAIGN

In Uttarakhand, existing health services are underutilized, facilities are understaffed and under-equipped and accessibility to healthcare products and services is a major challenge. This environment, compounded by a geographically challenging landscape, present problems to improving health in the region. The Sambhav Voucher Scheme was developed to reach vulnerable populations with free of cost health interventions. The voucher scheme links vulnerable groups to critical FP and RH services by providing quality products and services to BPL families free of cost at accredited private health centers. ASHAs provide vouchers for services including sterilization for men and women, OCPs, condoms, IUCDs, institutional delivery, ANC, PNC, and newborn care. Families then take vouchers to nursing homes/private hospitals for quality services at no cost. Involving both public and private healthcare providers in the implementation of the voucher scheme encourages competition, while maximizing healthcare quality and access to beneficiaries.

The voucher scheme aims to:

- enhance RCH services and coverage among BPL populations.
- provide access to quality healthcare services for mothers and children of BPL families.
- establish a system for accrediting healthcare facilities and ensuring quality of care.

- offer a choice of service providers to members of the community; and
- expand services across additional health areas, and in geography.

The voucher scheme in Uttarakhand was originally piloted in Imlikheda and Bahadrabadd blocks of Haridwar district between May 2007 and March 2009, where rates of institutional deliveries and childhood immunization are among the lowest in the state. Less than one-third of women deliver babies in a health facility, less than 10 percent of women receive full ANC, and less than one-quarter of children are fully vaccinated, so it was important to expand access to healthcare to communities in Haridwar.[4] Building on the pilot voucher scheme in two blocks of Haridwar district, the Government of Uttarakhand decided to expand the approach to 38 blocks in five districts: Almora, Dehradun, Haridwar, Nainital and Udham Singh Nagar. These districts encompass more than 50 percent of the state's rural population and have a large presence of private providers, which are nearly absent in the upper Himalayan regions of the state. Scale-up, as discussed below, has been carried out in two phases: October 2009 to March 2011 and April 2011 to March 2012.

Strategic Approach and Objectives:

This integrated campaign included conducting a formative study, developing the BCC strategy, designing a 360-degree campaign, and providing technical assistance to the state to implement this effectively.

Audience: Couples with one or more children

Couples wishing to have no more children

Mothers-in-law and other influencing family and community members

Service providers in the private sector

[4] Haridwar Baseline Survey 2006: Imlikheda and Bahadrabadd Blocks (Constella Futures, June 2007)

Key implementing partners and decision-making level stakeholders.

Duration: Pilot: May 2007 – March 2009.

Scale up in two phases: October 2009 to March 2011 and April 2011 to March 2012.

Key Interventions and Activities:

A. Formative Assessment: A formative assessment was done in 2010 to gain an appreciation on issues of concern. The **communication needs assessment** was conducted to map knowledge, attitude and behaviors of BPL families with regard to their utilizing of services for FP and institutional delivery, both of which are offered in the Sambhav voucher scheme. The assessment mapped potential barriers among BPL families to accept and utilize these services offered in the scheme, along with their media consumption patterns. A qualitative research study, utilizing focus group discussions and in-depth interviews with respondents from BPL families and health service providers was conducted.

B. BCC Strategy: Based on the needs assessment, a comprehensive BCC strategy was developed and handed over to the state. The strategy used a range of communication theories and models, namely the Pathways Health Competency Model for social and behavior change, the Trans-Theoretical Model of behavior change, the Orbit of Influence to understand social influencing factors and McGuire's Hierarchy of Effects to design the media-mix for the program.

The strategy focused on segmenting audiences and reaching them through multiple activities to reduce barriers, focusing on enabling factors, and using positive deviants to create a 'chain reaction' of behavior change. Through proper harmonization of interpersonal counseling, community-based health facility level and mass media campaigns and activities, individuals (at different life stages) were exposed to multi-layered opportunities to understand, observe and practice the recommended FP/RH behaviors and seek services under the scheme.

C. Multimedia Campaign: Based on this BCC strategy, a multimedia campaign was developed to address the following:

- increase adoption of positive health behaviors related to FP/RCH and increase in positive attitudes towards these
- increase awareness and knowledge about the Sambhav voucher scheme, including processes involved, services available, facilities offering these services and the brand among BPL families
- increase the utilization of the Sambhav voucher scheme by BPL families for FP, as per life stage needs
- change in attitudes of family elders and other influential leaders regarding spacing and limiting childbirth; and
- strengthen the capacity of service providers in client–provider interaction.

The BCC campaign used multiple, reinforcing media channels to disseminate messages to intended audiences including IPC by ASHAs,

ANMs, other healthcare providers and influencers within the family and community; community media at the village level to ensure localization of activities and messages; facility level media to improve service related transaction and mass media to inform and shape social norms. This media mix is based on media consumption patterns in each state, key points of contact, and the strengths and shortcomings of mediums.

Campaign Tag Line: *Coupon Lao, Sehat Pao* ("Get the Coupon, Get a Healthy Life") was a rhythmic, motivational slogan subliminally aimed to convey the message that changing times call for changing attitudes to healthcare, and that the quality of life is very important for the happiness and health of the entire family.

Campaign Materials:
Mass media: One TV and radio commercial that tracked a young couple using the multiple vouchers according to life stage in a catchy folk jingle was developed. It aired on state level TV and radio channels. These TV and radio commercials were also used as display content during health fairs and other events.

Film on the Sambhav Voucher Scheme: A 10-minute film was developed on the Voucher Scheme to be displayed as a mid-media level activity such as in mobile vans or in the waiting areas of the health facility. This film contained the details about the scheme, how to avail vouchers, processes involved, details about the vouchers, how it can benefit the clients, etc. This film incorporated a television shopping program treatment that reinforces the key motivating propositions of the scheme in different ways.

Scrolls for local cable TV: Animated scrolls at the bottom of the television screen were developed to be displayed through local cable network channels. These ads were district specific, providing contact details of the hospitals accredited under the Voucher scheme.

Branding materials for accredited nursing homes and hospitals: A range of branding materials was developed to highlight the Sambhav brand and the scheme. This was after the findings from a rapid assessment in Uttarakhand in 2010 that indicated that the brand was not recognized. In addition, it was necessary that the clients become familiar with the entire range of coupons available for the services offered by the program from

branding materials. Thus, tin plates and posters were developed and placed at different locations in the hospitals.

Outdoor mid-media: Hoardings and wall paintings were displayed at strategic locations in the town and cities where the scheme was implemented.

IPC level materials: Community level workers and health promoters used materials to provide more detail about the scheme. They included a flipbook, leaflets and a directory of accredited nursing homes and clinics.

ADOLESCENT HEALTH CAMPAIGN

The Government of Uttarakhand, through the Himalayan Institute of Health Training (HIHT), developed and delivered a life skills education program for youth. This presented the IFPS project with a unique opportunity to enhance the existing HIHT youth program by adding messages addressing issues of health, hygiene, choices about marriage and childbirth, and education. Utilizing HIHT's training module format, youth could be reached with BCC messages on these important topics. To accomplish this, the *Understanding and Delivering to Address Adolescent Needs* (UDAAN) program was developed. The pilot was implemented in five blocks of each of the five districts. In the scale up, the state included all the blocks within the five districts of Uttarakhand.

Strategic Approach and Objectives: To make healthcare services more accessible and acceptable to youth by building skills and capacity, and empowering youth to:

- increase utilization of services in adolescent-friendly clinics and counseling centers;
- improve health by positively impacting behaviors such as consumption of weekly iron foliate supplements, and improved menstrual hygiene for girls;
- reduce unhealthy high-risk behaviors through empowerment for abstinence from smoking, drinking and sexual activity;
- delay age at marriage for boys and girls;
- reduce school dropout rates;
- build skills and capacity, and empower parents to tackle barriers that make it difficult for youth to access services;
- increase service usage at adolescent-friendly clinics by setting standards and expectations for quality;
- build capacity of healthcare providers to improve service delivery in adolescent-friendly clinics; and
- establish a convergence of stakeholders in providing a comprehensive package of services for adolescents based on their needs.

The UDAAN Campaign

'Taiyaar Ho' (Get Ready)

This inspirational campaign motivates adults to help adolescents **get ready** for a healthy, successful and bright future. Materials display youthful animation, and use bright colors depicting energy and vigor.

Audience:

- Youth 14–19 years
- Rural, school going and out-of-school adolescent boys and girls
- Married adolescents.

Duration: Pilot August 2009–May 2010. Scale up: June 2010–March 2012.

Interventions and Activities:

Formative Study: A formative study was undertaken to understand the communication needs, aspirations and role models of the adolescents.

BCC Strategy: An integrated campaign and related materials to advocate for adolescent needs and rights, inform adolescents about healthcare, inform caregivers about their role, increase demand for adolescent services, and change attitudes of adolescents, caregivers and service providers towards adolescent health.

Peer Group Educator's Toolkit: A comprehensive toolkit was developed for peer group educators to conduct over 150 hours of interactive workshops/sessions with out-of-school adolescents. The kit contains materials, games, reference materials etc. on the following key areas:

- Marriage and FP
- Awareness of disease and vaccination
- Hygiene practices
- Utilization of health services
- School going habits
- Personality issues.

BCC Multimedia Campaign: An integrated campaign was developed that reached adolescents, caregivers and service providers at multiple contact points under the program. Mass media was not part of this campaign, given that the program was implemented in only five districts.

Twenty-five different types of materials were developed, including interactive board games, storybooks, healthy lifestyle booklets, leaflets, dispensers for socially marketed products, posters, banners, letter boxes, referral cards, and birth preparedness kits.

Results: The BCC strategy and campaign materials were handed over to the Uttarakhand Health Society in May 2010. Stakeholders were trained in using these materials effectively. The state invested money from the NRHM PIP to print and distribute these materials to the five districts.

CAPACITY BUILDING

Training and Tools for the ASHA-Plus Scheme

The NRHM aims to employ one ASHA for every 1,000 people, however, given Uttarakhand's hilly terrain, houses are distant and sparsely situated, and health services are difficult to access. Because of these unique challenges, under the ASHA-Plus program in the state, each ASHA serves only 500 people. Additionally, in Uttarakhand, there is very low media access, and a highly trained and well-equipped ASHA may be the only skilled healthcare provider available to many households. It is critical that ASHAs in these regions receive enhanced training on FP and RCH products and services, and be well-equipped with tools for effective IPC, health needs assessments, and referrals to hospitals or clinics. To deliver services through ASHAs with enhanced training and tools, the Government of India called for the scale up of the ASHA-Plus scheme in Uttarakhand.

Strategic Approach and Objectives: To build increased capacity among ASHAs, the primary and at times only trained healthcare provider accessible by communities, and equip ASHAs with tools to improve health of women and children by promoting:

- improved healthcare seeking behaviors among pregnant women;
- institutional delivery through the JSY;
- improved home-based newborn care; and
- routine immunization for children.
    - Build increased capacity among ASHAs to deliver effective BCC through IPC on hygiene, sanitation and nutrition.
    - Build increased capacity among ASHAs to effectively facilitate group meetings on priority health issues, and develop effective linkages with health program managers and PRIs.
    - Revitalize the Village Health and Sanitation Committee (VHSC) with support of ASHAs, supervisors, ANMs and AWWs.

'Now we are recognized in the village. People have faith in us and depend on us for their health services'.

Audience: ASHAs in Uttarakhand.

Duration:
Pilot phase: 2007–2009.

Scale up: Began in 2009.

Interventions and Activities:

The ASHA-Plus program was piloted in two blocks of Uttarkashi (Bhatwari and Purola), Chamoli (Karnaprayag and Joshimath), and Pithoragarh (Munsyari and Munakot) districts. One of the major components of this program was the in-depth training of the ASHA-Plus workers on IPC, health interventions and community mobilization.

- A baseline survey was conducted in the six pilot blocks and three non-ASHA-Plus blocks to generate estimates of healthcare knowledge, awareness, access and identify gaps for training.
- Based on these findings, an ASHA-Plus training model and curriculum was developed:
    - The training followed a participatory approach with

interactive discussions, group activities and group work, demonstrations and role plays, and audio-visual presentations.
    - Implementing communication activities, and developing communication materials were part of the training to encourage ASHAs to be self-reliant.
    - The training materials and curriculum leveraged existing health training materials and curricula from the Government of India. Content included training the ASHA in the life cycle approach and life skills education to identify needs of families and provide prioritized, need-based, client-centered services.
- A cascade training model was developed where master trainers, supported by representatives from the state and district health departments, and NGOs were trained by an independent agency, who then trained select ASHAs as master trainers in intervention blocks.

Given the limited access to healthcare resources in Uttarakhand, and the great need for services by ASHAs, the ASHA-Plus scheme provides the flexibility, enhanced training, and job aids needed to support an enhanced level of health services. Unlike the ASHA, the ASHA-Plus worker uses simplified and more illustrative training materials and job aids such as flipcharts on FP and RH choices, to help perform their work. Further, the ASHA-Plus worker is supported by a robust MIS that streamlines the workflow.

Results: Through the pilot program, 571 ASHAs were trained. The Uttarakhand Health and Family Welfare Society recognized the higher quality of healthcare provided by ASHA-Plus workers and began replicating the model across all 13 districts.

- A robust MIS was developed that included establishing a Technical Advisory Group to review program implementation.
    - ASHAs were provided registers for recording activities
    - Monthly reporting formats and Supervisor and Block Coordinator monitoring formats were developed;
    - Household survey formats were developed and were conducted by ASHAs in their areas.
    - Software was developed for MIS; with social mapping and ELCO mapping done by ASHAs for their coverage area.
- On an ongoing basis, the ASHA recruitment process, training process and operating systems are documented to enhance the program.

Analysis of quarterly performance reports continually finds improvements in healthcare knowledge, awareness, access and outcomes of the ASHA-Plus delivery process. MIS data show a steep increase in indicators related to early registration of pregnancies, institutional deliveries, immunization and improvements in other community issues like water, hygiene and sanitation.

MOBILE HEALTH VANS

To increase access to health services in Uttarakhand, mobile vans were deployed providing diagnostics, health consultations, and FP products and services to communities with limited access to healthcare facilities. A communication strategy was needed to scale up the program and service usage. Through community led mobilization, usage of services from mobile health vans improved during the pilot program launched in the Ram Nagar block of Nainital district. Based on this improvement, the Uttarakhand Health Society desired to scale up the mobile health van program.

Strategic Approach and Objectives: To develop a communication strategy that focuses on benefits of the mobile van program through a communication needs assessment to:

- increase awareness of health services available through the mobile van program, including information on schedules, costs, registration and medicines; and
- increase utilization of mobile van services by focusing on the benefits of the program.
  - Create a brand for the mobile van program that positions the van's health services as efficient, economical and of high quality.
  - Strengthen capacity of service providers and improve client–provider interactions.
  - Strengthen skills of service providers in IPC, community mobilization and advocacy.

Audience:
Primary: Married couples, adolescents.

Other: Family elders, community opinion leaders and ASHAs.

Duration:
Pilot phase: 2007–2009.

Scale up: 2010.

Interventions and Activities
Commission a communication needs assessment to identify communication needs, and most effective channels to increase mobile van brand recognition, and message recall and comprehension. Based on the communication needs assessment, develop a branding and communication strategy and materials to promote the program and increase service uptake.

- Advocacy and awareness communication materials developed:
  - Posters, wall writings and paintings
  - Mobile SMS alerts, loudspeaker messages, and one-page van handouts
  - Community groups, street plays and puppet shows
  - Counseling takeaways and portable counseling materials
- Branding:
  - Brand name and logo
  - Van paintings
  - Merchandising
- Capacity strengthening materials for van staff and ASHAs:
  - Orientation programs
  - Training programs and refreshers.

TABLE 14: FP/RCH SERVICES ACCESSED (DECEMBER 2007 – APRIL 2008)

Service	Clients
ANC	1,454
OCP cycles	1,908
IUCD	237
Condoms (10-pack)	5,406
Sanitary napkins	1,473
Total RCH Clients	**5,566 (36 percent of total turnout)**

Results: The mobile van initiative was fully functional from December 2007 until April 2008, during which 273 camps were held, 15,558 clients attended and received services in the camps, of which 67.4 percent were women and 34.5 percent were from BPL families.

Linkages with stationary public health facilities and regular follow-up visits have maintained the credibility of services provided. In addition to medical services, the van staff has trained village health volunteers in mobilizing members of the community to seek RCH services, and to provide BCC.

The Uttarakhand Health Society replicated this model to scale up the program in 13 districts across the state.

LESSONS LEARNED AND PROMISING APPROACHES

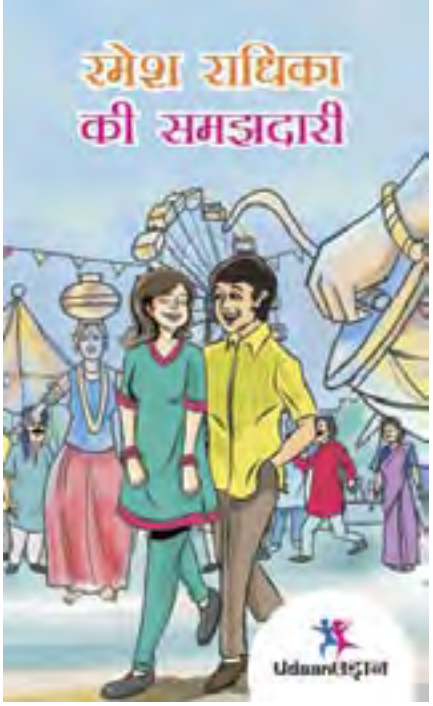
Social customs adhered to by families and community gatekeepers present unique barriers to programs that seek to increase uptake of services. Barriers must be understood through formative assessments, and can be addressed with participatory and collaborative approaches.

- Challenges remain in efforts to increase access to healthcare products and services in key populations.
  - Services are inadequate to address the perceptions, barriers and needs of youth.
  - Providers are ill-equipped to address the needs of youth.

Before scaling up programs, pilot programs can provide useful information with fewer resources. This was demonstrated in the successful scale up of the mobile van program, and re-design of voucher scheme communication materials that were needed as a result of implementation before the pilot assessment was completed.

- The rapid assessment of the voucher scheme demonstrated the need to reduce text, increase visuals, and portray local representations of people in communication materials.

Through the development of strategic BCC campaigns for key health issues in this unique region of India, new insights were gained in addressing



communication needs where traditional channels did not exist.

- Communication needs assessments are critical to the development of communication strategies for specific audiences that may be difficult to reach, such as healthcare providers in remote areas, or adolescents.

Through capacity building, providers of healthcare services themselves can be very effective media channels for communicating programs and services when other communication channels are poor or non-existent.

- IPC
- Positive client–provider interactions
- Mass and mid-media, such as loudspeaker announcements and van paintings.

Existing and accepted structures can be utilized to expand or enhance healthcare capacity among critical participants or audiences, effectively leverage resources, and increase stakeholder participation.

- Develop training modules for youth that expand on youth modules delivered by HIHT.
- Enhance skills of ASHAs through the expansion of the ASHA-Plus scheme.

WHAT WORKS

- Communication needs assessments for unique audiences and populations.
- Normalizing and positive role models motivate audiences to adopt a positive behavior.
- Audiences understand economic benefits, both short and long term, thus, campaigns need to explore these routes.
- Fixed dates and service delivery points establish credibility of services, and can be effective BCC.
- Scaling up pilot programs is most effective if assessment, monitoring and evaluation are components throughout the design, development, training and implementation process.

REFERENCES AND LIST OF RESOURCES

Section 1: National Level

- Proposed BCC Plan of Action for FP for the NRHM for July 2009–March 2010
- BCC Plan of Action for FP for the NRHM for July 2009–March 2010: Phase Matrix
- National IEC Workshop Report
- NRHM Advocacy Film Proposal by Relative Media
- MCH-STAR Evaluation Top Line Findings Presentation
- MCH-STAR Evaluation
- Atmajaa Proposal
- Study on Assessing the Visibility, Comprehension and Recall of TV campaigns aired under the NRHM

Section 2: Uttar Pradesh (many of these resources can be found at: www.sifpsa.org)

- BCC Strategy for the NRHM in Uttar Pradesh
- Interview with Rita Banerjee
- Interview with Geetali Trivedi
- Background document on the ASHA Newsletter
- ASHA Newsletter Presentation
- Rapid Qualitative Assessment Key Findings
- Mid-Term Evaluation Report: Radio Drama Series
- Project Management Unit Guidelines for Sterilization
- Interviews with SIFPSA staff
- PAC Presentation (PowerPoint)
- Kumbh Mela PAC Project Summary Report
- SIFPSA Information Sheet

Section 3: Jharkhand

- Objectives of the Jharkhand BCC Strategy Development Workshop Presentation
- Health Communication Strategy Jharkhand
- Health Issues and Health Seeking Behavior of Tribal Populations
- Intra-Communication Workshop Report and Summary
- Proposal for BCC Vouchers, District Dhanbad; September 1, 2009
- Proposal for BCC Vouchers, District Gumla-GN; August 6, 2009
- Proposal for Jharkhand Needs Assessment

Section 4: Uttarakhand

- Proposal for BCC-Institutional Deliveries, Uttarakhand
- ASHA Training Program Implementation Framework Presentation
- ASHA-Plus Project: IFPS project Presentation November 26, 2007
- Mobile Van BCC Plan-Uttarakhand ITAP Report September 3, 2009
- Motivating Rural Communities Presentation by the Technical Advisory Group
- Vikalp Formative Research Pilot Report
- Communication Plan Mobile Van Formative Report
- BCC Strategy for Voucher Scheme in Uttarakhand
- Haridwar Voucher Scheme Rapid Assessment
- UDAAN BCC Plan-September 9, 2009
- BCC Plan – Adolescent Health Presentation-August 8, 2009

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