Samagra Swasthya Sanchar

State IEC/ BCC Strategy

2005-08

Implementation Framework (Draft)

State IEC-BCC Strategy Implementation Framework for 2005-08

Annex

Introduction

Samagra Swasthya Sanchar– the health communication strategy of Department of Public Health and Family Welfare, Government of Chhattisgarh sets the direction for a new vision and mission for health communication and promotion in the state. The strategy shifts gears, from the former approach of programme-based and disease control driven IEC to a public health approach where proactive health promotion is the major focus. This strategy published in September 2005 is for the next three years. The Strategy itself is adaptable and carries the scope to evolve in response to changes within the health sector and the overall development scenario in the state. After three years it will be reviewed and re-crafted and based on the implementation experiences and emergent needs.

An implementation framework has been developed taking into account this strategy, which seeks to translate the commitment to 'health in the hands of people' into practical ideas/ views/ suggestions/ guiding principles that will yield tangible results. This document, the **Implementation Framework**, details how the strategy will be implemented in practice. It will act as the guide over the three-year tenure of the Strategy for the setting up of appropriate implementing and monitoring mechanisms and institutions, fulfilling capacity building needs, development of priorities, plans and messages - in short for achieving the Strategy's overall aims and actions.

Intended for both the health programme managers and health communication managers, the document is organized into seven chapters. Each of these chapters spells out the scope of action and a summary of action points from all the chapters is incorporated in Chapter VII.. Definition of key terms is also annexed to promote a shared and consistent understanding of concepts and terms.

Institutional Structure and Functions

Scope

The State IEC/BCC strategy delineates four strategic objectives and for each of these five operational strategies. But effective implementation of these depends upon the ways in which these objectives and strategies are interpreted and implemented by actors whose own perception is mediated by the nature of institution(s) within which they would be working. In fact the strategy would have no effect if either the people did not act on or according to it. This chapter will spell out the institutional structures, the human resources requirement, the competencies needed, the infrastructure and technology needed within the health and allied sectors.

State Level institutions

While the strategy is premised on the fact that each of the three geographic and cultural regions of the state has its distinct needs and specific social and behavioural environment and advocates a region specific, settings-based and locale-specific approach facilitated by a decentralised IEC function, it is certain that some of the technical resources and competencies are easier to make viable at the state level. Moreover for these regional institutions to reach full functional status would take time. Till such time the state would have to play this role. Also for ensuring inter-sectoral co-operation as envisaged under the NRHM it is important to exploit state level institutions and optimize their contribution by streamlining their functions and establishing the right linkages.

The existing structure and staffing should be revamped and instead of the IEC bureau in practice in other states, a state level communication resource hub should be considered. This resource hub should play a supportive and mentoring role for the district and regional centres. It should be located physically in the newly constructed State Institute of Health and Family Welfare but should have its own administrative and operational identity. The centre should have only the essential number and type of staff in keeping with the functions allocated to it. All specialty jobs have to be out-tasked.

IEC Cell

The IEC cell in the directorate must continue for a number of key functions. Its central task would include public relations and organising events for the department like the organization of health department displays on national days and for the rajyotsav, conduct of state level exhibitions, press releases and advertisements, media advisories and communiqué etc.

The IEC cell would also look after personnel administrative issues of IEC personnel and linkage with government of India's IEC wing, providing reports to the government and facilitating the needs of all the state and district training centers with the directorate and the government.

The officer in charge of the IEC cell, would also be one of the members of the governing body of the SIHFW and the convenor of the inter-sectoral coordination committee for IEC.

Health Communication Resource Hub and the SIHFW

A Health Communication Resource Hub should be created within the SIHFW. This will assume and perform a range of functions corresponding to its role as the lead agency for the implementation of the state IEC/BCC strategy. It will serve as a standard-setter, a capacity builder and a catalyst. It will be a platform for bringing together resources from different programmes and also interact with technical support partners outside the department. As the SIHFW is also the state's apex training institution, SIHFW will play an important role in ensuring synergy between health programme implementation and IEC activity. It would also groom district health communication managers, and health communicators besides facilitating compilation and updating a database of electronic material for communication related trainings.

The Health Communication Resource Hub will have one senior faculty and three health communication professionals. Till such time as the regional centers become operational the personnel of the regional centers would also function from this hub.

Technical Support Partners

These will make available the necessary support and input to the Communication Resource Hub. These will comprise of leading existing health technical resource agencies UNICEF, SHRC and RRC. It would also include leading NGOs with technical health expertise such as CARE, ActionAid, RAHA, Jan Swasthya Sahyog, and NGOs associated with RAN – Resource Agency Network. Any other technical support agency of international funding agencies or of other allied departments would also find place. These would be organised along with partners from allied sectors in the form of a coordination committee.

Allied Sector Partners

These will be the institutions from the allied sectors that have an area of overlap with health. These would draw from the IEC cell of the Women and Child Development, Communication Capacity Development Unit under Public Health Engineering, the SIRD of the Panchayat and Rural Development especially and SCERT under School Education. Besides these the Directorate of Public Relations and the Field Publicity Office of GoI would also be involved.

State Level Committee For IEC

The State Health Society would have an IEC sub-committee to make the IEC plan and implement the IEC activities. This committee would be chaired by the Mission Director and the officer in charge of the IEC cell would be its convenor. The committee would have as its members the State Programme Officers, State and one representative each of the Technical Support Partners and would meet once every quarter.

An inter-sectoral IEC committee with officer in charge of the IEC cell would also be needed to ensure co-ordination between various allied sector and technical support partners and the health department.

State Level Institutions and Their Functions

Institutions	Functions	Competencies
IEC cell	▸ Ensure coverage of all achievements, events, tour programmes of the health department in the state, regional and local media ▸ Organize exhibitions and similar events ▸ Disseminate of reports, publications etc. ▸ Establish and maintain linkage with government of India's IEC wing, providing of reports to the government ▸ Facilitate the needs of all the state and district training centers ▸ Handle personnel administrative issues of IEC personnel	Event management; Public Relations; Administrative staff management; Report writing; Documentation & dissemination
Health Communication Resource Hub in SIHFW	▸ Identify and provide resources and expertise on formative research, operational research, and monitoring of change indicators through in and out –tasking. ▸ Develop and execute a mass media plan based on the needs flagged by the Regional Centres and the districts. ▸ Procure relevant and quality material such as films, print material etc. to develop a reference and resource section and appropriately disseminate it to the field. ▸ Establish and maintain an interactive website for health communication materials, strategies and methodologies. ▸ Establish and maintain a phone helpline dedicated to providing information on health issues. ▸ Publish a quarterly newsletter for internal and external communication. ▸ Ensure integrated planning approaches and inter-sectoral coordination and convergence at the State level ▸ Coordinate and collaborate with various support agencies, media and donors ▸ Develop suitable capacity building modules for Training of Trainers. ▸ Build and update a database of training material on communication. ▸ Provide mentoring and support to the regional health communication hubs.	All aspects of BCC including planning and management, training of trainers, message and material development, relevant research; Working with designers, creative artists, preparing TORs; Building linkages, advocacy & mentoring;
Technical Support Partners UNICEF SHRC RAN CARE RRC	▸ Identify health communication priorities as well as help with audience profiling leading onto the development of media mix. ▸ Develop behavior change objectives and indicators and critical messages for different population-groups and health risks (covered under national programmes and others) ▸ Conduct research and impact evaluations ▸ Provide hand-holding support to ear-marked districts	BCC, community mobilization; Technical proficiency in specific areas like RCH, gender ; Qualitative research;

Allied sector Partners CCDU SIRD SCERT	▸ Include the module on health in their training programmes ▸ Contribute to making health departments programmes more holistic. ▸ Programme implementation for defined audience segments like SIRD for panchayat functionaries.	BCC and technical proficiency in specific areas

Regional Institutions- the proposed RIHFWs

The emphasis on locating IEC/BCC strategy primarily in the proposed regional institutes of health and family welfare at Bilaspur, Ambikapur and Jagdalpur is based on the fact that the state comprises of three ecological regions which coincide with distinct life-style patterns of the people in these three regions. These three regions can be said to comprise three cultural zones in the state, though we note that even within these three broad zones there is considerable cultural heterogeneity. To develop a region specific media-mix instead of following a uniform and linear strategy through-out the state, both the formative research and the material development and even the training of trainers is best done at this level.

The HRD (Training) policy of the state has already recommended establishing Regional Health and Family Welfare institutes at Ambikapur; Bilaspur and Jagdalpur to serve as centers of training male and female paramedical staff to work as supervisors/health assistants as well as for guiding the district training centers and leading the IEC/BCC programmes in each of these three regions. The IEC work in these institutes should be organised in the form of Health Communications Hubs pretty much on the same lines as the Health Communication Resource Hub within the SIHFW. Till such time a separate infrastructure is made available to the regional centres the DTCs in these districts shall play this role in coordination with the SIHFW.

The functions of these Communication Resource hubs are therefore the same as for the State Health Communication Resource Hub – only it would be region specific. The staff proposed is also one senior health communication faculty, and three communication/community health professionals and the requisite support staff.

Institutions	Functions	Competencies
RIHFW	▸ Carry out formative research for designing BCC initiatives. ▸ Prepare and maintain audience profiles based on the results of research and evaluations. ▸ Define the behaviour change objectives and indicators based on research and in consultation with the districts and state level institutions ▸ Undertake pre-testing of message and materials in their region and among the various population groups. ▸ Collect local k*issa*, kahawats – proverbs, stories, folklore and vocabulary on health among the various ethnic and socio-cultural groups. ▸ Make an inventory of home remedies in use. ▸ Maintain necessary databases. ▸ Organise and implement the capacity building, research and evaluation functions.	BCC planning Plan, conduct and use formative communication and social research (including baseline and end line evaluations); Message design, pre-test & material development; Training and mentoring ; Monitoring & Evaluation ; Reporting and documentation;

	▸ Design pre and post evaluations. ▸ Training of trainers for health communication work and training of health communicators. ▸ Mentoring and support to district training centers and district health communication work for planning and programme implementation.	

District Level

The district health society would have a district IEC sub-committee to make the IEC plan and implement the IEC activities. One of the four programme officers of the district who has been trained in health communication would chair this committee and the DEMO would be the convenor for the committee. The district training center programme staff would also all be trained to function as committee members. The block extension educators (renamed BETO) and district resource persons of the Mitanin programme would also be members of this committee. Three non governmental representatives who would provide technical support would be one representative each of an identified state level technical agency earmarked to provide support for each district, a district level NGO with past health communication/Mitanin programme experience and the district mother NGO. More representatives of civil society and other allied departments may be included where relevant. This committee may meet as and when needed but not less than once in a quarter. The most active and capable five or six members of this committee can form a task force who would do the studies and undertake the programme planning and monitoring, meeting as often as necessary to achieve their tasks.

Institutions	Functions	Competencies
District IEC sub-commitee	▸ Design and develop Health IEC/BCC District Plan based on health programme indicators through a task force constituted for this purpose. Finalise the plan and submit to district health society for its approval. ▸ Implement the above plan with leadership provided by the IEC task force.. ▸ Design context specific messages and material. ▸ Mobilise civil society resources available within the district. ▸ Contribute regularly to the departmental newsletter	Programme planning and implementation; Plan and conduct PRCA/ PRA and Appreciative Inquiry; Conduct formative research; Selecting media- and provider mix; Programming and designing material in locally suitable formats; Organising events;
DTC	▸ Develop own technical capacity to make the district IEC sub-committee effective. (All DTC programme staff are members of this sub-committee). ▸ Integrate IEC/ BCC relevant capability building into all paramedical and medical training programmes. ▸ Support the Regional Health Communication Hub within the RIHFW in all its functions and use the pre and post evaluations for programme improvement.	Participatory communication and training methodologies; Training in health communication;

	▸ Consolidate the feedback from the blocks and share it with Regional and State level Communication Resource Hubs. ▸ Contribute regularly to the departmental newsletter. ▸ Maintain necessary district-level databases and a library.	
District Rural Health Mission/ District Health Society	▸ Constitute the district IEC sub-committee. ▸ Approve the annual plan for IEC. ▸ Ensure adequate inter-sectoral participation. ▸ Review the programme implementation.	Basics of BCC Recruiting partners & linkages Advocacy

Block Level

The BETO is the convenor and all the supervisors are members of the block IEC team. The BMO leads this team. Block resource persons of the Mitanin programme and civil society active in those blocks may also be included in this team. It has been proposed in the Strategy that team training would be organised at the block level to promote a shared understanding of health communication and a team approach to communication related work.

Institutions	Functions	Competencies
BETO and the block health management team	▸ Support the District IEC subcommittee in all its functions. ▸ Implement the district IEC plan as appropriate for the block. ▸ Implement on the job capacity building of Mitanins, Dais, ANMs, AWWs, MPWs in IPC, and other forms of BCC in synergy with the RIHFW and DTC. ▸ Collect feedback from the field on the campaigns, initiatives and interactions with the community. ▸ Help the district design context specific messages and material. ▸ Maintain necessary block-level databases, especially tracking the beneficiaries of different schemes etc. for using them in advocacy.	Co-ordinating tasks, prioritizing, organizing and problem solving; Using basic PRCA/ PRA; Using different media , including mass media; Facilitating and monitoring health communication activities; Working with different groups – low literacy/ gender/ ethnicity/ school children / adolescents/ youth/ elders; Negotiation counselling and consensus building;

GP, Village & Hamlet Level

At the panchayat level the IEC work is integrated with all health planning and implementation work through the statutory panchayat health committee. The ANMs, Anganwadi workers and the trainers of Mitanins besides themselves carrying out IEC activities will provide technical support to these committees. At the hamlet level the women's health committee and /or the self help group plays the role of communicators with the Mitanin. The ANMs and the Mitanin trainer will together provide training and support to the Mitanins and the above mentioned women's groups.

Institutions	Functions	Competencies
ANMs, MPWs	▸ Carry out the planned health communication activities ▸ Collect feedback from the community and share it with the Supervisors and BETOs ▸ Train and support the Mitanins in carrying out IEC / BCC	PRA; Counselling and consensus building; Using basic communication aids;
Mitanins	▸ Play a proactive or supportive role as necessary to disseminate health messages ▸ Undertake community mobilization ▸ Network with women's groups/ SHGs and involve them in advocacy ▸ Share local knowledge with ANMs, Supervisors, BETOs, help them understand the target audiences and learn out about the local context and culture	Working with different groups; Using basic communication aids; Motivating, mobilizing and engaging people;

Capacity Building

Scope

The State IEC/BCC strategy envisages a paradigmatic shift from IEC to BCC and proactive health promotion. One of the key operational strategies (section4.3, page 14 of Strategy document) mandates re-skilling the IEC staff and re-orienting the decision makers for the paradigm shift. This would call for changing attitudes, strengthening the knowledge base, developing new skills and competencies and acquiring newer technology and work tools. This section will spell out the different capacity needs of various functionaries within the department and outside and suggest some options for building and enhancing these capacities.

Capacity building is to be seen as more than training. It should involve not just enhancing the knowledge but strengthening skills, making technology available and accessible and shifting to enabling management practices and policies. Also it must be consistent with the functions the personnel have to perform and must be an integral part of the job description for IEC and other health sector personnel at all levels. Capacity building measures must not be limited to preparing personnel to perform current functions but must also prepare them to perform future functions especially given the fast changing communication scenario and technologies.

To the extent possible the motivation and individual differences of personnel must be considered while proposing any capacity development options for them. Steps must be taken to ensure that there is enough scope for application of what is being learnt in the immediate future.

The capability building needs that exist at different levels for implementing the strategy relate to

- BCC planning and management
- Campaign design and implementation
- Design and development of appropriate material
- Training methodologies for development of health communication skills
- Event management
- Evaluation, supervision and facilitation
- Reporting and Documentation
- Participatory methodologies
- Communication Research
- Negotiation & Advocacy

Capacity Building Needs for Various Groups

Communication related skill needs
(Note: All skills of the peripheral level are part of the higher level too)

STATE	REGION	DISTRICT	BLOCK	GP/ VILLAGE
Setting-up BCC objectives and indicators Campaign design and implementation Working with designers, creative artists, preparing TORs Preparing reference material Building linkages Advocacy Documentation & dissemination Mentoring	Setting-up BCC objectives and indicators Formative research (design & analysis) Message design & material development Selecting media and provider mix Training methodology Mentoring Monitoring and Evaluation Reporting	PRCA/ PRA/ AI Formative research (implementation) Selecting media- and provider mix Training in health communication/ BCC Recruiting partners & linkages Advocacy Programme management Programming and designing material in locally suitable formats Organising events	PRCA/ PRA Use of different media and their deployment Facilitating and monitoring health communication activities Working with different groups – low literacy/ gender/ ethnicity/ linguistic minorities youth/ adolescents/ school children/ elders Negotiation counselling and consensus building Organising events all as in GP level plus kala jatthas, special days & sammelans etc.	PRA Carrying out FGD and small group discussions / role play Collecting case-studies/ testimonies and feed back Working with different groups – low literacy/ gender/ youth/ adolescents/ school children/ elders Counselling and consensus building Using basic communication aids Organising events e.g. swasthya melas / rally/ cultural art forms/ meetings/ public discussions/ debates/

AI – Appreciative Inquiry; BCC- Behaviour Change Communication; FGD – Focus Group Discussion; PRA- Participatory Rural Appraisal; PRCA- Participatory Rural Communication Appraisal; TOR – Terms of reference;

Capability Building Approach

Capacity building must be carried out in a phased manner moving from the essential to desirable for both the existing and new staff. Since it would not be possible to train the entire staff, especially at the field level, at one go, a rotational policy should to be adopted for training the staff in which each year a proportion are trained in one aspect and the others in the remaining. For instance at the field level some can be trained in planning, some in research and the rest in implementation aspects. In this way in three years all the staff would have had the necessary training.

Senior management

Sensitization on current trends in health communication/ BCC for all Joint Directors should be mandatory. Some of the top management could be sent for national/ international courses like for example the John's Hopkins University – Advances in Health Communication Workshop organised every year at Administrative Staff College of India at Hyderabad. Another option could be to invite the university to organize a special course in Chhattisgarh. Exposure to successful implementation of BCC initiatives will be another way of ensuring that health communication and its scope are appreciated better. A sensitization on the determinants of health particularly in gender and poverty issues as proposed in the strategy document for the top management and this should be undertaken in the first year of implementation of the strategy.

State and Regional IEC Officials

For senior IEC programme management in the SIHFW and the RIHFWs the best available trained/ experienced professionals would be hired from the open market. Their skills by definition are expected to be already good enough, though professional peer review and exposure to other work in seminars and exchange visits and individual academic work would be essential to update and maintain these skills. The IEC cell would of course be filled in by promotion and it would be necessary to upgrade the incumbents' skills within a year by a suitable national course.

At the regional level too, one way of ensuring that the IEC personnel have the requisite capacity and competencies is to recruit professionally trained staff by direct recruitment. But it is unlikely for us to be able to hire all the staff so required. Also, as the full complement of skills may not be available, it would be necessary to build their capabilities further through training, peer learning, mentoring and exposure visits. For direct recruitment to the SIHFW and RIHFW fresh graduates from professional institutions like the Mudra Institute of Communication, Ahmedabad; Indian Institute of Mass communication, New Delhi; Jamia Milia Islamia University, New Delhi; Students with Masters in Social Work or Journalism or Communication from other recognised institutions may be taken on contract.

District Level

At the district level direct recruitment may be tried. But almost certainly adequately qualified people with experience would not be available for the salaries that are possible. Also most of these posts should be available for promotion from the BETO cadre. For both those who are directly recruited and promoted into these posts it would be necessary to build their capabilities further through training, peer learning, mentoring and exposure visits.

Personnel to be trained in IEC at the district level must include Programme Officers, DTC staff besides the IEC staff. In the past also multi-disciplinary teams have been trained in all the sixteen district and this approach has worked well.

Block Level and peripheral Staff
These include the medical officers in the CHC and PHC, the BETO, the ANMs, MPWs and their supervisors and even the support staff of the PHCs and CHCs. Since in practice the functions of many of these staff are so interchangeable and since all medical officers and BETOs have to supervise and support the other functionaries on IEC work it is useful to have a similar capability approach to all these staff.

The proposed approach is for all training programmes to always include an appropraite training on IEC/ BCC, especially in the periodic refresher training that has been envisaged under the training policy. The DTCs being the site of such training, all DTC staff have to necessarily be skilled in training methodolgy and curriculum needed for imparting health communication skills. Also since the ANM and the supervisors have to train Mitanins, dais and panchayat functionaries to act as health communicators some training skills are also needed for these staff. The DTCs should absorb some of the Mitanin trainers especially from the state training team so as to provide it with the capabilities to train Mitanins, dais, panchayat functionaries and civil soceity members.

Mitanins
Being local residents they are familiar to a large extent with the culture and practices. However, they now need to be trained in using the above as a spring-board for initiating discussions and BCC. All Mitanins need to be equipped with health communication skills and tools. More specifically they need skills in using basic communication aids, counselling and consensus building. This skill building would be done by the Mitanin trainers with support from the ANMs.

Others

NGOs
NGOs, especially those involved in service delivery under the mother NGO scheme or the Mitanin programme, or in State AIDS control programme would require capacity building on BCC aspects. The DTCs and RIHFWs would be the site for this.

SHGs
Self-help groups and other women's or youth groups, village health committees are expected to act as advocacy groups. They need communication and advocacy skills, particularly if they take on a significant role in building a supportive environment. The DTCs and RIHFWs would be the site for this assisted by the Supervisors and the Mitanin training cadre.

Material developers / artists
The state though rich in traditional folk art and media is not tuned in to the market needs of a focussed and specific product development (kala kattha, radio or TV programme). One of the crucial inputs required for the strategy would be the capacity building of these diverse groups of material developers, event managers and artists. This need may be addressed through especially designed trainings/ workshops.

Message, Media and Communicators

Scope

The overall strategy and approach as defined in the state IEC/BCC strategy (page 10) calls for adopting a life styles perspective instead of a bio-medical or psycho-social approach or focusing narrowly on behaviours. It further emphasises the need for segmenting audiences, adopting an audience centred perspective and drawing on formative research to put together an appropriate media mix and provide mix instead of a one dimensional and linear approach. To translate this broad approach into specific actions, this section outlines messages, media and communicators mix as understood currently. This would now form a base on which further understanding should evolve; while simultaneously kick starting implementation in the current year.

One of the operational strategies under the strategy (section 4.1) is to ensure a shared and consistent understanding of health priorities, needs, change indicators and critical health messages across different levels within the department. The approaches suggested include defining behaviour change objectives and indicators for each of the different audience groups. It is suggested that a reference document outlining the critical health behaviours and lifestyle and behaviour change indicators should be compiled and disseminated at all levels. The messages, media and communicators in some important areas are being outlined below. They are based on the integrated district plans developed earlier and on the inputs from Technical Support Partners.

- Malaria
- Institutional Delivery
- New born Care Practices
- Management of the Sick Child
- Effective ANC
- Child marriage
- Alcoholism

The Behaviour and Key factors related columns relate to the messages that need to reach the intended audiences and Activities column outlines the media and communicators. It is reiterated that these are to be treated as indicative only and are not exhaustive.

Malaria

Audiences	Behaviour	Key factors	Activities
All rural families and individuals including children above 10 years Parents of children below 10 years Families of pregnant women	Use protection against mosquitoes in the form of nets, oil or other repellents, daily. Make special efforts to protect pregnant women and young children > 5, from mosquitoes Periodic action to destroy potential breeding sites within home and in neighbourhood. Seek help of local paramedical health care provider to have a slide made as soon as a case of fever happens in the family. Take the complete prescribed dose when suffering from malaria	▸ Information on possibility of a fever being malaria and their own susceptibility to it ▸ Information that blood slide is the way to know whether any fever is malaria ▸ Information that malaria is spread through mosquito bite and that it is possible to reduce the chances of getting it. ▸ Motivation to protect self, family and neighbourhood from Malaria especially pregnant women and small children. ▸ Motivation to control the breeding of mosquitoes through individual and collective efforts. ▸ Link morbidity due to malaria to eventual loss of income ▸ Skill in identifying and destroying the breeding places. ▸ Skill in seeking timely and the right service at the hamlet/ village level ▸ Services available to enable the community act on the messages.	▸ Small group discussions by Mitanins/ ANMs and MPWs using display material showing breeding sites and different methods especially locally relevant ones with different groups ▸ Motivational Inlands letters to Panchayat representatives before every gram sabha on actions to destroy the breeding sites ▸ PRA after gram sabha and Shramdaan to destroy mosquito breeding sites ▸ Wall paintings depicting use of mosquito nets especially in absence of cots in households ▸ Wall paintings in schools and hostels and colleges ▸ Quiz or other specially designed fun activities like 'Macchar mar daud' (Mosquito destruction race) under the school health programme
INDICATORS	▸ Increase in use of protection against mosquitoes especially nets (revealed in rapid fever surveys) ▸ Decrease in SPR and API from previous year	▸ Recognize fever as a possible case of malaria ▸ Able to recall how malaria spreads and list actions that can protect ▸ Able to point out potential breeding sites in the neighbourhood ▸ Recount action to be taken to destroy the site ▸ Able to name the nearest place/person for blood test and medicines (identify Mitanin)	▸ Development, production, distribution, deployment of the material in adequate no. ▸ No. of group discussions in which the issue was discussed ▸ PRA carried out ▸ Variety/ range of activities undertaken at the school level ▸ No. of panchayat reps reached through letters received by

Institutional Delivery

Audiences	Behaviour	Key factors	Activities
Families of pregnant women Panchayat members	Mothers, especially those at high risk, seek institutional delivery where there is an acceptable affordable facility available Families of pregnant women esp the husband / elders discuss and plan and make the necessary arrangements for the delivery as soon as the risk is discovered	▸ Information on reasons for institutional delivery and on the nearest accessible affordable facility ▸ Motivation to go there, esp if high risk ▸ Skill to plan for how to organise transport at the moment of need and access relevant govt. schemes /facilities ▸ Enabling environment that makes such behaviour the desired norm ▸ Availability of the services being prescribed/promoted/ promised	▸ Mitanins, AWWs and ANMs between them ensure that the pregnant woman and her family are counselled. IPC using printed flip charts/flash cards. Special attention to high risk women. ▸ Locale specific success and adverse case stories publicized through gram panchayats and at all local events and health melas. ▸ Mitanins trained and supported to help such families to plan – using all available resource including JSY etc ▸ Radio jingles and TV slots and folk art used to make this behaviour the status norm- we are ready to change- ▸ Stone pillars at public place at the hamlet and village level informing about the available and functional institutional delivery facility
INDICATORS	▸ Number of women seeking institutional delivery where there is affordable, accessible service available compared to previous year/ last three months ▸ Micro-plans made for pregnant women in last trimester with Mitanin's help	▸ Pregnant women able to tell whether they are at risk and recall the risk, where is the facility and what is the scheme ▸ Husband/ Elders in family of pregnant woman able to tell whether the woman is at risk, the nearest available facility, and whether she is eligible for help under any of the schemes ▸	▸ Communication material available with Mitanins ▸ Samples show that they have been used at hamlet level. ▸ Case studies pamphlets compiled and distributed on time ▸ Radio jingles broadcast and TV slot payments and cassette of the above freely distributed for dissemination ▸ Stone pillars with information erected at the stipulated place

New born Care Practices

Audiences	Behaviour	Key factors	Activities
Pregnant women Families of pregnant women Doctors and health care providers	Breastfeeding initiated within the first hour Mother fed nutritious diet from first day Children weighed in first day Babies kept warm- and not bathed for three days esp if low weight Low birth weight babies taken for referral if appropriate referral facility accessible, BCG injection taken	▸ Information on the reasons for these changes ▸ Effectively counter the existing understanding of not feeding baby or mother for first 3 days. ▸ Skill to identify what is nutritious diet ▸ Skills of initiating sucking reflex, taking weight and managing start up problems. ▸ Creation of family level and community level enabling environment for these changes based on information of why this is needed ▸ Ensuring that doctors and other health care providers are supportive - not detrimental to these behaviours ▸ Information about the nearest accessible affordable referral centre for the low birth weight baby	▸ Small scale formative research on the barriers to the recommended behaviours ▸ Home visit and counselling to the pregnant woman's family - supported by flip charts /flash cards- by Mitanins or AWWs or ANMs during the pregnancy and on the day the child is born. ▸ Radio jingles and TV spots on the six messages to make this behaviour the status norm - we are ready to change - ▸ 'Dear Doctor' letters to all doctors and to be met by "sales representatives" for breast milk ▸ Sensitisation programmes for health care providers with a printed set of FAQs based on formative research ▸ Wall paintings/stone pillars announcing facility for low birth weight babies
INDICATORS	▸ % of women who breastfed in first hour ▸ % of women given full diet on the first day ▸ % of newborns weighed in first three days ▸ % of LBW babies who sought referral care where it was affordable and accessible	▸ Women who has recently given birth to a child can recall the above as the steps she needs to take, can ▸ Public awareness of this issue and the campaign ▸ Can name the nearest referral centre ▸ Unprompted recall among doctors and other health care providers of above behaviours	▸ Number of women who were visited on the first day of child-birth. ▸ Number of sensitization programmes held ▸ Content, quality and choice of place for wall paintings/ stone pillars ▸ Dear Doctor letters designed and used ▸ Availability of FAQs with health care providers

Management of the Sick Child

Audiences	Behaviour	Key factors	Activities
All rural families especially with children below 5 years ANMs/AWWs and Mitanins School children	Use ORS solutions as prescribed in case of diarrhoea Use of home remedy if trivial ARI and avoidance of injections for the above Seek help of local paramedical health care provider to distinguish between home care, first contact care and need for referral in cases of fever, ARI or diarrhoea	▸ Information and skill (why, how & how much) to use ORS for diarrhoea, home remedies in trivial ARI and first contact care in fever ▸ Information and skill to differentiate between trivial and serious illness and the need to consult the local health volunteer for this ▸ Skills to give home remedies and seek Mitanin's help ▸ Recognize and question existing harmful beliefs and health care seeking practices for this context ▸ Information about affordable and accessible referral centre for the sick child and neonate ▸ Information and skill to recognize underlying preventable factors if diarrhoea or ARI recurrent	▸ Compilation of useful home remedies and disseminated to workers for use during discussions ▸ Mitanins/ AWWs and ANMs between them hold discuss with women's groups and at gram sabhas ▸ Incorporate message in kala Jattha to be held after gram sabha ▸ One visit to all houses by a team asking families to seek Mitanin/ANM/AWW help on the very first day if there is any one of these problems ▸ Special hoardings/posters/ Wall writings announcing need to consult the ANM/AWW/Mitanin to differentiate between trivial illness and serious illness ▸ Inputs during school health programmes for prevention of recurrent infections and for prompt care
INDICATORS	▸ No. of children with diarrhoea given adequate ORS in the previous month ▸ No. of children with diarrhoea, fever ARI,who consulted the health worker and % of this who needed referral in the previous month ▸ Decrease in % of children who were given injections for ARI	▸ Knowledge of the role of first contact care ▸ Skills to make and administer ORS ▸ Able to tell why to use ORS ▸ Public awareness and recognition of the work of first contact care	▸ Number of times issue has been discussed in gram-sabha and panchayat meetings ▸ Number of school health education programmes held ▸ Number of folk art programmes with this message held in the block.

Effective ANC

Audiences	Behaviour	Key factors	Activities
All families with pregnant women or eligible couples Gram panchayat Service Providers and health volunteers	Seek not only an antenatal check up but insist on a complete and good quality antenatal check up	▸ Recognize all 8 elements of a complete ANC and the reasons for each (early registration, abdominal examination, weight record, blood and urine examination, BP measurement, iron and folic acid tablets and TT injections) ▸ Motivation to co-ordinate with AWW/Mitanin and ANM so as to access these services. ▸ Effective supervision of quality and access by community and gram panchayat	▸ Small scale formative research on current practices and barriers to the recommended behaviour ▸ Persuade local sirha/ gunia to counsel the families of pregnant women ▸ Mitanins/ AWWs and ANMs between them visit all pregnant women ▸ Special meetings with women and approach through SHGs and gramsabha meetings for these messages. ▸ Special carry home print material announcing what is an ANC ▸ Sensitization programme for panchayat leaders.
INDICATORS	▸ No. of pregnant women who had complete ANC compared to previous year/ quarter's figure	▸ Service providers, volunteers and pregnant women and their husband/ family elders able to recall with reason the 8 elements of ANC ▸ No. who approve that these services are beneficial ▸ Able to tell where these services can be accessed	▸ No. of visit during which the above messages were discussed ▸ No. of meetings of SHGs held to discuss the above ▸ Content and quality of material produced and ▸ No. of sensitization programmes for pannchayat reps

Child/ Early marriage

Audiences	Behaviour	Key factors	Activities
Parents and grand parents of adolescent girls especially school drop outs from class 5th to 11th Jaatee panchayat members, religious heads chadeedaars etc. especially amongst patel, kurmi and sahu communities	Parents of young girls do not seek to fix match for daughters below 17 years. Parents of young boys do not entertain proposals for marriage for sons below 21 years Girls are not married off before completing 18 years and boys not before 21	▸ Learn about the rationale from the community's perspective ▸ Awareness on the disadvantages of early marriage for girls and also for such a couple and their children ▸ Aware of reasons for fixing the legal age of marriage ▸ Skill to withstand family, neighbourhood and community pressure ▸ Motivation through recognition as progressive and responsible parents ▸ Encouragement for the girls to pursue school education/ a vocational course/ skill building to participate in family or other occupation ▸ Motivation to parents to nurture and protect instead of punishing by marrying off the children at a young age	▸ FGDs with different population groups to understand the reasons and discuss solutions ▸ Use the above in positioning the messages ▸ Population group based shows of local art forms particularly bharthari / pandwani ▸ Inspirational story in the school text-book ▸ Advocacy through SHGs esp. at the time considered auspicious for fixing marriages and post-harvest ▸ Inclusion in the TV/ Radio soap ▸ Sensitization for Jaatee panchayat members/ leaders and recruiting champions ▸ Posters at community halls, panchayats etc ▸ Discussions and debates – "Swasthya ke sawaal aur aapke khayaal" ▸ Inter-sectoral activities with DWCD
INDICATORS	▸ Reduction in number of marriages below 18 years of age compared to last year/ season	▸ Able to list different disadvantages of early marriage ▸ Approve that it is detrimental ▸ Able to negotiate with family, neighbourhood and community at large to withstand the pressure for early marriage of self or in the family	▸ Messages incorporated in folk art performances ▸ Inclusion of story in text books through SCERT ▸ Development and timely use of posters at stipulated places ▸ No. and timing of sammelans of Jaatee panchayats where the issue was discussed ▸ Incorporation of message in radio/ TV soap ▸ Meetings and joint planning with DWCD

Nutrition

Audiences	Behaviour	Key factors	Activities
Primary Mothers of children under 1 yr, giving inadequate/ inappropriate weaning food **Secondary** Father of the child Mother in law and Sister in law	Start giving locally available complementary food at least 5 times a day from 6 months onwards besides breast milk	▸ Belief that child does not need food other than mother's milk ▸ Fear that introduction of food will cause diarrhea and lack of skill in dealing with the situation ▸ Inadequate knowledge of nutritious value of various food ▸ Belief that nutritious food is expensive ▸ Food related taboos and concept of hot and cold food. ▸ Absence of enabling environment for mother to take decision	▸ Mitanins/ AWWs and ANMs between them visit all mothers with children between 4-6 months to observe and find out about their knowledge and behaviour ▸ One to one counseling with mothers not planning to practice/ practising the recommended behaviour ▸ Special meetings with mother in law / sister in law to discuss food taboos etc ▸ Sensitization of the father through leaflets designed for the purpose
INDICATORS	▸ % of mothers with a child in the age-group 6 to 12 months who report having started complementary food ▸ The frequency and variety of food given to the child in last 24 hours in compliance with the recommended behaviour	▸ No. of mother of children in 5-12 months of age able to tell the correct age to begin complementary food, type of food to be given and frequency ▸ No. of mothers/ sisters in law who approve that giving complementary food at this age s beneficial ▸ No. of fathers of such children able to tell the right age for complementary food and to tell about how they facilitated this behaviour	▸ No. of visit during which the above messages were discussed ▸ Content and quality of leaflet produced

Audiences	Behaviour	Key factors	Activities
Primary Pregnant and lactating women **Secondary** Husband Mother in law and Sister in law	Women registering themselves at AWC within the first four months of their pregnancy An additional meal each day and varied diet for pregnant and lactating women Breast feeding shortly after birth including colostrum	▸ Belief that eating more will lead to child becoming big and this causing difficulty in delivery ▸ Inadequate knowledge of nutritious value of various food ▸ Belief that nutritious food is expensive ▸ Food related taboos and concept of hot and cold food. ▸ Absence of enabling environment for women to take decision	▸ Mitanins/ AWWs and ANMs between them visit all pregnant women ▸ One to one counseling with pregnant women and their family members ▸ Motivational posters / wall paintings about the responsibility as parents and decision making in favour of their own and child's health (for both men and women) ▸ Special meetings with mother in law / sister in law to discuss food taboos etc. ▸ Sensitization of the husband through leaflets designed for the purpose
INDICATORS	▸ % of pregnant women who register themselves at AWC in the first four months ▸ No. of women who had an additional meal in the last 24 hours ▸ Variety of diet in the last seven days ▸ No of women who fed colostrum to the new born	▸ No. of pregnant women able to tell the advantages of nutritious diet and the frequency and type of food to be taken ▸ No. of pregnant women and their family members able to give arguments in favour of an improved diet as against the fear that a bigger child would lead to difficult delivery ▸ No. of mothers/ sisters in law who approve of the need for an improved and additional diet ▸ Husbands of pregnant women who are able to explain the need and components of recommended diet	▸ Mitanins/ AWWs and ANMs able to list locally available and less expensive food ▸ Mitanins/ AWWs and ANMs able to explain the need for, the quantity and frequency of a proper diet during pregnancy ▸ No. of visit during which the above messages were discussed ▸ Content and quality of poster/ wall painting design and leaflet produced ▸ Place of display of wall paintings/ posters ▸ % of pregnant women/ their husbands exposed to the messages/ material

Alcoholism

Audiences	Behaviour	Key factors	Activities
All rural people especially adolescents and youth	Restrict alcohol consumption below alcoholic levels Alcohol related family violence is not accepted within the family and neighbourhood Limited alcohol consumption at high risk times like festivals	▸ Information about risks of alcohol ▸ Information on link between alcoholism and fall in productivity and rise in domestic violence ▸ Skills to differentiate between tolerable levels of alcohol consumption as norm of "acceptable behaviour" and alcoholism ▸ Skill in stopping such behaviour in family ▸ Zero tolerance for alcohol related violence. collective and individual	▸ FAQs in form of a pamphlet accompanied by audio cassettes of Kissa /songs depicting the risks and fall outs of alcoholism at all mela madhais/ haat bazaars ▸ Testimony videos as TV spots ▸ Tin boards at mandees, bus stops and local liquour shops with emotional appeals ▸ Community mobilization through PRCA against alcoholism and related behaviour ▸ Discussions with women's groups/SHGs/ panchayats and youths kendras ▸ Community action e.g. breaking of all alcohol pots and voluntary abstinence for a month if in any house there is alcohol related domestic violence plus individual penalties ▸ SHGs to play monitoring role and impose penalties- ▸ Special outreach to youth before festivals
INDICATORS	Reduced episodes of family violence in identified families	▸ Able to tell the risks associated with alcoholism ▸ Recount associated behaviour observed in family/ neighbourhood ▸ List steps to be taken to stop such behaviour	▸ No. and quality of printed and audio material ▸ Coverage of mela madhais through FAQ pamphlets and audio ▸ No. and placement of tin boards ▸ No. of PRCA held

Monitoring, Evaluation and Feedback

Scope

The State IEC/BCC strategy envisages planning for IEC and IEC programme implementation as one continuous activity. Evaluation and feedbacks are envisaged for constantly modifying programme designs and even objectives while planners through effective process and outcome monitoring ensure that the key objectives are being realised. (refer sections 4.1 to 4.5 of the strategy document). In this section the key indicators as well as the major activity forms that monitoring and evaluation would take are defined.

Indicators

Indicators help monitor the programme so that programme implementation is strengthened and eventually to evaluate the programme so as to understand what have been the outcomes and the constraints.

Two types of indicators are to be defined and collected - process indicators and outcome indicators. Outcome indicators would assess the change in behaviour whereas process indicators would inform us as to whether the activities through which this outcome is to be achieved have been undertaken with sufficient coverage and quality. Even as the process indicators capture an important performance aspect related to health communication efforts, some indicators of intermediate behaviour change would also be needed while undertaking BCC. They would essentially relate to the various steps in behaviour change for instance knowledge, approval, intention, trial and practice, not necessarily in that order. This would also help to monitor the relationship and movement between information/ knowledge, skills, motivation, enabling environment and behaviour change.

The choice of indicators for a few programme objectives has been detailed in the preceding section as an illustration of how indicators can be designed.

Monitoring and Feedback

Monitoring at each level of the programme is done by the higher levels of implementation structure. In addition community monitoring of programmes has to be evolved.

Monitoring by programme implementers would be largely based on field visits and on examination of reports from the functionaries. A revision of reporting formats to avoid duplication is proposed under the strategy.

To the extent that monitoring is supportive and facilitative the reports are more reliable and corrective measures easier to institute. This also implies that all monitoring would have to have a strong element of participation built into it. Thus planned periodic feedback sessions with the field level functionaries where programme planners and implementers listen carefully to the feedback from those at the cutting edge of the work would not only allow a better understanding of the programme but also provide better motivation to those who are

working on it. The correct choice and use of indicators would enhance the quality of monitoring.

Evaluation

Evaluation can be of outputs and of outcomes or of the impact. Necessarily these should be both an internal evaluation by the programme management supplemented by an end of the programme external evaluation as well. The latter should necessarily be outsourced. Internal evaluation would require a good knowledge of evaluation methodology and should not be confused with feedback or data aggregation from the field. Help from professional consultants may be required for designing the evaluation and for the analysis of data. Outsourcing for external evaluation needs a skilled development of a TOR so that a professionally competent evaluation is obtained. The relevant competencies are expected to be available at the state and regional hubs (see Chapter 1). Assistance of Technical Support Partners can also be taken for developing suitable TORs and identifying the right agencies for the task.

BCC Management

Scope:

There are three aspects addressed in this section. The first is the resource requirements, the second is the key action plan elements and the third is the issues of financial management. This section draws together the key action points from the earlier sections into a summary.

Resource Requirements for BCC management

One of the main functions of the Communication Resource Hubs at the state and regional levels is to create the resource pool needed to implement the IEC/BCC strategy. Capacity building is the most important part of this resource creation, but it is not the only part. Information and knowledge warehousing and Material creation support are the other key resources that are needed. Technology and equipment support also needs to be ensured at various levels.

Information and Knowledge needs

The changed approach proposed under the strategy calls for expanding the information and knowledge-base to include determinants of health, individual and collective behaviours, cultural practices etc. Some of the critical information and knowledge gaps that the formative research, that preceded the drafting of the strategy and implementation framework, showed are listed below. These are reflected in the Samagra Swasthya Sanchar document also.

- Determinants of health
- Health needs at various stages of life-cycle
- Common health problems and their management at different life stages
- Stages/ conditions requiring expert care
- Individual and collective behaviour that contributes to ill health
- Health priorities, change indicators and critical health messages
- Service delivery structure, ongoing schemes and entitlements
- Health as peoples' right
- Role of PRIs and other local institutions in helping people access health services and schemes

Other than the above there are areas of knowledge e.g. related to national health programmes, which also require a resource base. This knowledge resource base is not listed above as it is expected that it would be made available from the programme planners and implementers of these programmes. The Communication Resource Hubs need not be charged with creating this as their priority.

Material Creation Resources

- Graphics and photographs collections.
- Database of creative artistes and illustrators.
- Warehouse of already existing health communication material with ready access when needed.

Technology and Equipment Needs

- Desk top publishing and design systems at state and regional hubs.
- Software and skills for data analysis.
- Animation and graphic tools and software.
- Mobile Projection systems
- Proper workplace/workstations for IEC staff.

Key Action Plan Components

The following are the main elements of the immediate work plan.

Action Plan Component	Implementing Agency.
Formation of district IEC sub-committee and task forces	District Health Society.
Formation of State Coordination Committee for IEC	Mission Director, State Health Society.
Annual State IEC plan: Especially for material development and capacity building and for research inputs. Also the media-message mix for state level dissemination. (See annexure 3)	State and Regional Communication Hubs working together. Also coordinating with allied sectors. Approval by State Health Society.
District IEC plan- integrated with district health planning.	District IEC committee and approval by district health society/mission. Support from technical support agencies.
Creation of State Health Communication and Regional Health Communication hubs	Approval in administrative setup and where needed contracting out this function.
Creation of Resource base for the functioning of the communication hubs	By the SIHFWs and the three DTCs(while awaiting the formation of the RIHFWs) with assistance of the technical support partners.
Recruitment of Professional Staff in the IEC bureau and in the Communication Hubs	Outsource to suitable technical support agency.
Revised job profiles for Existing IEC personnel.	Issue of orders for the same and Inclusion in Medical manual.
Implementation of Action Plan for capability building and for material development with quarterly progress reports	State Health Communication Resource Hub
Implementation of Action Plan for state level media mix	IEC cell, Directorate of Health Services.
Implementation of District IEC plans with quarterly progress report	District IEC task force/ district health society

Financial management:

The resources needed for implementing the IEC programme of action based on the strategy can be made available if carefully planned for. The following table indicates a possible sourcing of funds for the next five year period. It indicates that the implementation framework is not overly ambitious or impractical. It can be the immediate plan of action, starting now.

Budgetary Component	Source of Funds
IEC cell	State budget
State Communication Resource Hub	SIHFW operationalisation costs under EU-SPP
Regional Communication Hubs	DTC operationalisation costs under EU-SPP
Training Programmes for capability building	RCH-II
District IEC plan implementation	RCH-II and pooling the IEC funds of all the other disease control programmes. RCH-II funding currently is Rs 1 per capita on IEC. This needs to increase to Rs 5 per capita. But for the first year a beginning can be made with Rs. 2 to 3 per capita. Allocation to districts can be done on an agreed to formula based on mix of population norms, geographical dispersion and health needs.
District personnel costs	State Budget
Technical support agencies	From their core support budgets for handholding districts and contributing to the state resource hubs. Plus from RCH-II for workshops and commissioned work.
NGOs	From within the district plan budgets.

Budgetary Aspects

Scope

This section elaborates the norms for budgetary allocation for various levels and activities. It also spells out the tentative budget requirement for implementation of the strategy in its first year.

As mentioned earlier the implementation of the strategy can be managed within the budgets available to the state under the various programmes. The total budget for implementing the strategy would be approximately Rs. 700,00000.

Norms for budget allocation

1. The districts should be allocated funds @ Rs. 2 to Rs. 3 per capita for non-tribal and tribal districts respectively. Within this the allocation for various sub-heads should be done as follows

Sub-heads	Rate per capita
Material development and production	Rs. 0.50
Capacity building	Rs. 0.35
Activities and events at the community level	Rs. 0.50 (non-tribal districts) Rs. 1.00 (tribal districts)
Activities/ Hoardings / events at the district level	Rs. 0.25
Monitoring & Evaluation / Programme management	Rs. 0.45 (non-tribal districts) Rs. 1.00 (tribal districts)
Total	Rs. 2.00 (non-tribal districts) Rs. 3.00 (tribal districts)

2. Any deviation from the above norms is acceptable and welcome. However, the pre-requisites for such deviation would be that the district should make a presentation to the State IEC/BCC co-ordination committee in its full meeting. This committee would have the powers to approve this deviation and the minutes of any discussion on the deviation would be duly recorded. This is simply to ensure that the central expenditure like hoardings and events remain within the ceiling and material development costs are reasonable.
3. Mass media like films, TV and radio production will be undertaken at the state level and the budget for this will be provided at the state level. Any district

Annex 1 : **Snapshot of Strategy**

Annex 2 : **Definition of Key Terms**